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S. HRG. 99-729

PINE RIDGE RESERVATION CLAIMS AND IMPROVEMENT OF THE HEALTH STATUS OF NATIVE HAWAIIANS

#223 ORIGINAL

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

ON

S. 2260

TO SETTLE CERTAIN CLAIMS ARISING OUT OF ACTIVITIES ON THE PINE RIDGE INDIAN RESERVATION

S. 2243

TO IMPROVE THE HEALTH STATUS OF NATIVE HAWAIIANS, AND FOR OTHER PURPOSES

MAY 7, 1986
WASHINGTON, DC

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CERTAIN CLAIMS ARISING OUT OF ACTIVITIES ON THE PINE RIDGE INDIAN RESERVATION, AND TO IMPROVE THE HEALTH STATUS OF NATIVE HAWAIIANS

WEDNESDAY, MAY 7, 1986

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 2 p.m., in room 124, Senate Dirksen Office Building, Hon. James Abdnor presiding.

Present: Senators Andrews, Inouye, Abdnor, Murkowski, and Gorton.

Also present: Representatives Akaka and Heftel.

Staff present: Pete Taylor, staff director; Patricia Zell, staff attorney; Ipo Lung, professional staff member; Dick Doubrava, professional staff member; and Debbie Storey.

STATEMENT OF HON. JAMES ABDNOR, U.S. SENATOR FROM SOUTH DAKOTA, AND MEMBER OF THE SELECT COMMITTEE ON INDIAN AFFAIRS

Mr. ABDNOR [presiding]. The Subcommittee on Indian Affairs will be in order. This afternoon we will hold this hearing to discuss S. 2260, a bill to provide for the settlement of certain claims arising out of activities on the Pine Ridge Indian Reservation, and a similar bill, S. 2243, sponsored by Senator Inouye, to improve the health status of native Hawaiians and for other purposes. First we will discuss S. 2260.

[The text of S. 2260 and S. 2243 follows:]

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II

99TH CONGRESS
2D SESSION

S. 2260

To settle certain claims arising out of activities on the Pine R'dge Indian Reservation.

IN THE SENATE OF THE UNITED STATES

MARCH 27 (legislative day, MARCH 18), 1986

Mr. ABDNOR introduced the following bill; which was read twice and referred to the Select Committee on Indian Affairs

---

A BILL

To settle certain claims arising out of activities on the Pine Ridge Indian Reservation.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) in full settlement of all claims, legal and equitable, against the United States arising out of activities on the Pine Ridge Indian Reservation that were the subject of the findings of fact and recommendations submitted to the Senate by the Chief Commissioner of the United States Court of Claims (Congressional Reference 4-76) in response to a request of the Senate made in Senate Resolution 378 (94th Congress,

agreed to on August 9, 1976), the Secretary of the Treasury is authorized and directed to pay, out of funds in the Treasury of the United States not otherwise appropriated, the following amounts:

(1) $731.05 to Joe Leavitt (claimant No. 1),

(2) $118,771.10 to William Leavitt (claimant No. 2),

(3) $10,954.48 to Dwight W. and Francis Afraid of Hawk (claimant No. 3),

(4) $15,073.31 to Stella Bear Shield (claimant No. 4),

(5) $3,582.00 to Samuel Crooked Eyes (claimant No. 5),

(6) $2,955.00 to Seth Eagle Bear (claimant No. 6),

(7) $4,095.00 to Frank and Gonne A. Grooms (claimant No. 7),

(8) $2,537.00 to Vera High Hawk (claimant No. 8),

(9) $21,092.00 to John and Nancy Hussman (claimant No. 9),

(10) $2,245.00 to Jackson and Carolyn Iron Horse (claimant No. 10),

(11) $4,467.00 to Frances Ice Chase (claimant No. 11),

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(12) $1,838.60 to Eugene Kills in Water (claimant No. 12),

(13) $3,161.00 to Victoria Little Moon (claimant No. 13),

(14) $4,929.00 to Clement and Verla Locke (claimant No. 14),

(15) $12,021.56 to Frank and Gladys Locke (claimant No. 15),

(16) $11.672.50 to Charles and Martha Moose (claimant No. 16),

(17) $12,812.00 to Warfield Moose (claimant No. 17),

(18) $8,025.00 to Patrick and Sophia Pumpkin Seed (claimant No. 18),

(19) $6,161.25 to Oliver and Margaret Red Eagle (claimant No. 19),

(20) $24,562.00 to Paul and Eva Red Star (claimant No. 20),

(21) $7,768.00 to Lillian and Steve Sitting Eagle (claimant No. 21),

(22) $1,685.10 to Joseph Spotted Bear (claimant No. 22),

(23) $5,897.25 to Elizabeth Breast (claimant No. 23),

(24) $3,340.33 to Elmer and Nettie Two Two (claimant No. 24),

(25) $7,653.00 to Francis and Marie Randall (claimant No. 25),

(26) $5,603.00 to Fannie Bear Eagle (claimant No. 26),

(27) $3,597.00 to Eugene Black Bear, Jr. (claimant No. 27),

(28) $2,571.00 to Anthony and Linda Black Elk (claimant No. 28),

(29) $15,833.90 to Homer and Irene Black Elk (claimant No. 29),

(30) $8,762.75 to Rachel Eagle Bull (claimant No. 30),

(31) $4,723.00 to Florine (Ice) Hollow Horn (claimant No. 32),

(32) $6,050.40 to Oscar and Rachel Hollow Horn (claimant No. 33),

(33) $4,134.40 to Verlean Ice (claimant No. 34),

(34) $6,880.00 to Claudia Iron Hawk Sully (claimant No. 36),

(35) $7,735.55 to Paul R. Littlebear-Taylor (claimant No. 37),

(36) $3,248.10 to Hobart Keith (claimant No. 38),

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(37) $1,350.00 to Mathew H. King (claimant No. 39),

(38) $4,285.00 to Dallas and Roselyn Little Bear (claimant No. 41),

(39) $3,053.60 to Julia Little Bear (claimant No. 42),

(40) $2,083.09 to Mrs. Theresa R. Means (claimant No. 43),

(41) $3,842.00 to Carol E. Red Star (claimant No. 44),

(42) $1,194.00 to John Mark Red Star (claimant No. 45),

(43) $3,793.50 to Neville C. Red Star, Sr. (claimant No. 46),

(44) $3,525.00 to Darlene Rosane (claimant No. 47),

(45) $14,882.00 to Garry Rowland (claimant No. 48),

(46) $2,485.00 to Beverly Running Bear (claimant No. 49),

(47) $4,025.00 to Rose Shott (claimant No. 50),

(48) $24,276.00 to Sub-Community of Wounded Knee (claimant No. 51),

(49) $3,750.00 to Paul Thunder Horse (claimant No. 52),

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(50) $3,593.00 to Robert E. & Lorene E. Thunder Horse (claimant No. 53),

(51) $5,949.22 to Timothy H. and Audrey K. Thunder Horse (claimant No. 54),

(52) $1,900.00 to Lester White Butterfly (claimant No. 55),

(53) $1,455.00 to Daniel Dodge (claimant No. 56),

(54) $1,100.00 to Mr. & Mrs. Manfred Fast Horse (claimant No. 57),

(55) $2,207.00 to Helen S. Grant (claimant No. 58),

(56) $4,715.00 to Florine Hollow Horn *ex rel.* Bernard Ice, Sr. (claimant No. 59),

(57) $1,245.00 to Frank Jealous of Him (claimant No. 60),

(58) $5,756.10 to Matthew and Bessie J. High Pine (claimant No. 61),

(59) $5,305.00 to Cecilia (Little Moon) Fast Horse (claimant No. 62),

(60) $4,901.50 to Mabel I. Whiteface (claimant No. 63),

(61) $3,288.00 to Rachel White Dress (claimant No. 64),

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(62) $2,422.30 to Dorothy Fast Wolf (claimant No. 65),

(63) $13,018.40 to Frank H. and Wilma Grooms (claimant No. 66),

(64) $4,334.67 to Jessie and Raymond Red Shirt (claimant No. 68),

(65) $28,467.95 to Carol J. Deckert Sager (claimant No. 69),

(66) $2,484.45 to LeRoy "Sunshine" Janis (claimant No. 70),

(67) $16,754.70 to Rudolph Fire Thunder (claimant No. 71),

(68) $1,535.50 to Messiah Episcopal Church (claimant No. 72),

(69) $1,984.26 to Ivy Goings (claimant No. 74),

(70) $2,679.60 to Dorothy Mae Richards (claimant No. 75),

(71) $1,640.00 to Elizabeth Bradshaw (claimant No. 77),

(72) $6,184.00 to Charles Dixon Sasse (claimant No. 78),

(73) $5,740.70 to Orville and Emma Lansberry (claimant No. 79),

(74) $2,129.00 to Oscar Jealous of Him (claimant No. 80),

(75) $1,984.26 to Delores Apple (claimant No. 82),

(76) $2,502.80 to Chris Hatchett (claimant No. 83),

(77) $1,920.00 to Gilbert L. and Mary A. Matthews (claimant No. 85),

(78) $5,623.00 to Irene Jumping Eagle (claimant No. 86),

(79) $69,461.83 to St. Paul Insurance Companies (claimant No. 87),

(80) $1,650.00 to John Siers (claimant No. 88),

(81) $5,505.00 to Ameilia M. Clark (claimant No. 89),

(82) $50,975.94 to George and Violet Coats (claimant No. 90),

(83) $51,290.45 to James A. Czywczynski & Jeanette J. Czywczynski (claimant No. 91),

(84) $18,436.58 to Federal Insurance Co. (claimant No. 92),

(85) $1,650.00 to Stephen E. and JoAnne Ferace (claimant No. 93),

(86) $12,331.14 to Guy and Jean Fritze (claimant No. 94),

(87) $7,000.00 to C and F Trucking (claimant No. 95),

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(88) $16,615.00 to Clive A. and Agnes Gildersleeve (claimant No. 96),

(89) $12,763.08 to Gordon G. and Lorraine F. Greenamyre (claimant No. 97),

(90) $21,917.51 to H and R Plumbing and Heating, Inc. (claimant No. 98),

(91) $39,298.25 to Home Insurance Co. (claimant No. 99),

(92) $21,457.92 to Janis Roofing (claimant No. 100),

(93) $6,431.95 to Milbank Mutual Insurance Company (claimant No. 101),

(94) $4,468.00 to Mary F. Pike (claimant No. 102),

(95) $67,511.54 to R and S Construction Company (claimant No. 103),

(96) $12,405.00 to Estate of Wilbur A. Riegert (claimant No. 104),

(97) $19,620.00 to Orville G. Schwarting (claimant No. 105),

(98) $490,934.44 to Sioux, Inc. (claimant No. 106),

(99) $8,275.02 to Stuyvesant Insurance Co. (claimant No. 107),

(100) $8,028.65 to Oglala Sioux Tribe (claimant No. 108),

(101) $28,374.00 to Oglala Sioux Housing Authority (claimant No. 109),

(102) $37,679.50 to Aaron DeSersa-Sron (claimant No. 110),

(103) $5,181.45 to Lydia Black Bear (claimant No. 111),

(104) $887.50 to Thomas Casey (claimant No. 112),

(105) $3,984.00 to Roy and Pauline White Butterfly (claimant No. 113),

(106) $3,495.00 to Eleanor Big Owl for George Iron Teeth (claimant No. 114),

(107) $3,168.09 to Standard Oil (Indiana) (claimant No. 115),

(108) $7,335.00 to Shirley Blunt Horn (claimant No. 116),

(109) $1,866.00 to Eugene and Vera Hunts Horse (claimant No. 118),

(110) $2,650.40 to Clayton and Vernice Jealous of Him (claimant No. 119),

(111) $1,021.00 to Keva A. and Reuben R. Mesteth (claimant No. 120),

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(112) $4,234.70 to Hobart Spotted Bear (claimant No. 121), and

(113) $1,425.00 to Employers Mutual Companies (claimant No. 122).

(b)(1) No part of any amount paid to any person under subsection (a) in excess of 10 percent of such amount shall be paid or delivered to, or received by, any agent or attorney on account of services rendered in connection with the claim for which such payment is made, and the same shall be unlawful, notwithstanding any contract to the contrary. Violation of the provisions of this paragraph is a misdemeanor punishable by a fine not to exceed $1,000.

(2) Pursuant to the recommendations of the Chief Commissioner of the United States Court of Claims, the Secretary of the Treasury is authorized and directed to pay, out of funds in the Treasury of the United States not otherwise appropriated, $26,486.44 to the Dakota Plains Legal Services, formerly South Dakota Legal Services Corporation for services rendered in connection with the proceeding conducted pursuant to section 2509 of title 28, United States Code, which was initiated by reason of Senate Resolution 378 (94th Congress, agreed to on August 9, 1976).

○

II

99TH CONGRESS
2D SESSION

S. 2243

To improve the health status of Native Hawaiians, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 26 (legislative day, MARCH 18), 1986

Mr. INOUYE (for himself, Mr. ANDREWS, and Mr. MELCHER) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

---

A BILL

To improve the health status of Native Hawaiians, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

FINDINGS

SECTION 1. The Congress finds that—

(1) the Federal Government retains the legal responsibility to enforce the administration of a public trust responsibility for the betterment of the conditions of Native Hawaiians by the State of Hawaii;

(2) in furtherance of the State of Hawaii's public trust responsibility for the betterment of the conditions

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of Native Hawaiians, contributions by the Federal Government to the provision of health education and health services to maintain and improve the health status of Native Hawaiians are consistent with the historical and unique legal relationship of the Federal Government with the government that represented the indigenous native people of Hawaii;

(3) it is the policy of the Federal Government to raise the health status of Native Hawaiians to the highest possible level and to encourage the maximum participation of Native Hawaiians in the planning and management of health services in order to achieve this objective;

(4) Federal support for programs that provide health care to Native Hawaiians has resulted in a reduction in the prevalence and incidence of preventable illnesses among Native Hawaiians and in a reduction in premature deaths of Native Hawaiians; and

(5) further improvement in the health status of Native Hawaiians is necessary on the basis of findings that—

(A) Native Hawaiians experience the highest age-sex standardized mortality rate in the State of Hawaii,

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(B) Native Hawaiians experience a lower life expectancy than any other population group in the State of Hawaii,

(C) Native Hawaiians experience a higher rate of infant mortality, congenital abnormalities and underweight infants than any other population in the State of Hawaii,

(D) Native Hawaiians have the greatest risk of diabetes, heart disease, and some forms of cancer than any other population in the State of Hawaii,

(E) Native Hawaiians experience the onset of diabetes, heart disease, and hypertension at earlier ages than other populations in the State of Hawaii,

(F) Native Hawaiians have significantly higher rates of heart disease and hypertension than other populations in the State of Hawaii,

(G) Native Hawaiians have one of the highest cancer rates of any population in the United States and Native Hawaiians have the poorest survival rates from cancer than any other population in the State of Hawaii,

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(H) Native Hawaiian pregnant women rank the highest of all populations of pregnant women in the State of Hawaii in—

(i) receiving late or no prenatal care,

(ii) smoking and alcohol consumption during pregnancy,

(iii) toxemia and urinary tract infections during pregnancy, and

(iv) complications of pregnancy over age 35,

(I) Native Hawaiians have higher rates of suicide among young adult and elderly males than the statewide population as a whole,

(J) Native Hawaiian children have one of the highest periodontal disease rates and the poorest dental hygiene of any other population in the State of Hawaii,

(K) Native Hawaiians have higher proportion of alcohol and narcotics use and school performance impairment than the statewide population as a whole,

(L) Native Hawaiians have higher levels of stress than the statewide population as a whole based on leading stress indicators,

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(M) Native Hawaiians are underrepresented in rates of participation in health education, health promotion, screening, and referral programs,

(N) utilization of mental health services by Native Hawaiians is significantly below that of other populations in the State of Hawaii, and

(O) Native Hawaiians are underrepresented in the health professions.

DEFINITIONS

SEC. 2. For purposes of this Act—

(1) The term "disease prevention" includes—

(A) immunizations,

(B) control of high blood pressure,

(C) control of sexually transmittable diseases,

(D) prevention and control of diabetes,

(E) pregnancy and infant care, including prevention of fetal alcohol syndrome,

(F) control of toxic agents,

(G) occupational safety and health,

(H) accident prevention,

(I) floridation of water, and

(J) control of infectious agents.

(2) The term "health promotion" includes—

(A) cessation of tobacco smoking,

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(B) reduction in the misuse of alcohol and drugs,

(C) improvement of nutrition,

(D) improvement in physical fitness,

(E) family planning, and

(F) control of stress.

(3) The term "Native Hawaiian" means any individual who has any ancestors that were natives, prior to 1778, of the area that now comprises the State of Hawaii.

(4) The term "Native Hawaiian organization" means any organization that—

(A) serves and represents the interests of Native Hawaiians, and

(B) is recognized by the Governor of the State of Hawaii for the purpose of planning, conducting, or administering programs (or portion of programs) authorized under this Act.

(5) The term "Secretary" means the Secretary of Health and Human Services.

HEALTH PROMOTION AND DISEASE PREVENTION

SEC. 3. (a)(1) The Secretary shall, in consultation with Native Hawaiian organizations, establish a program of health promotion and disease prevention designed to serve the Native Hawaiian population.

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(2) The program that is to be established under paragraph (1) shall—

(A) provide necessary preventive-oriented health services, including maternal and child health care and mental health care;

(B) provide for the collection of data related to the prevention of diseases and illnesses among Native Hawaiians, including the prevention of fetal alcohol syndrome, hypertension, heart disease, and diabetes;

(C) provide for medical and general health-related research into the diseases that are most prevalent among Native Hawaiians including, but not limited to, heart disease, hypertension, cancer, and diabetes;

(D) provide for research into the mental health problems that are most prevalent among Native Hawaiians including, but not limited to, alcoholism, substance abuse, reduction of stress, and child abuse;

(E) provide for education in health promotion and disease prevention in the Native Hawaiian population;

(F) provide for health planning in areas which shall include, but not be limited to, health planning in maternal and child health, nutrition, disease prevention, health promotion, health education, and mental health;

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(G) provide training for Native Hawaiian community health outreach workers as paraprofessionals in the provision of health care and health education in Native Hawaiian communities by means of a curriculum which—

(i) combines education in the theory of health care with supervised practical experience in the provision of health care,

(ii) provides instruction and practical experience in health promotion and disease prevention activities, particularly—

(I) nutrition,

(II) physical fitness,

(III) weight control,

(IV) cessation of tobacco smoking,

(V) stress management,

(VI) control of alcohol and substance abuse, including prevention of fetal alcohol syndrome,

(VII) control of high blood pressure,

(VIII) prevention and control of diabetes,

(IX) prevention of lifestyle related accidents,

(X) prenatal and postnatal infant health care, and

(XI) maternal health care, and

(iii) provides instruction in the most current and effective social, educational, and behavioral approaches to the establishment and maintenance of good health habits; and

(H) provide a centralized monitoring function which shall submit annual reports to the Congress through the Secretary on activities that—

(i) are designed to address the health care needs of Native Hawaiians, and

(ii) may be conducted by—

(I) the State of Hawaii,

(II) the Federal Government,

(III) community health centers,

(IV) Native Hawaiian organizations, or

(V) private health care providers.

(b)(1) Subject to the availability of funds appropriated under the authority of paragraph (3), the Secretary shall provide grants to Native Hawaiian organizations for the purpose of developing the management capabilities of such organizations to plan and operate the health promotion and disease prevention program that is to be established under subsection (a).

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(2) The total amount of grants that may be made to any Native Hawaiian organization under paragraph (1) shall not exceed $75,000.

(3) There are authorized to be appropriated $600,000 for each fiscal year for the purpose of funding grants under paragraph (1).

(c)(1) The Secretary is authorized to enter into an agreement with a Native Hawaiian organization under which the Secretary is authorized to assign personnel of the Department of Health and Human Services to such Native Hawaiian organization, or to the educational institutions of such Native Hawaiian organization, on detail for the purpose of providing education to Native Hawaiian children in health promotion and disease prevention.

(2) Any assignment of personnel made by the Secretary under any agreement entered into under the authority of paragraph (1) shall be treated as an assignment of Federal personnel to a local government that is made in accordance with subchapter VI of chapter 33 of title 5, United States Code.

(d)(1) The Secretary shall establish in the State of Hawaii, as a demonstration project, a Native Hawaiian Program for Health Promotion and Disease Prevention for the purpose of exploring ways to meet the unique health care needs of Native Hawaiians.

(2) The demonstration program that is to be established under paragraph (1) shall—

(A) provide necessary preventive-oriented health services, including health education and mental health care,

(B) develop innovative training and research projects,

(C) establish cooperative relationships with the leadership of the Native Hawaiian community, and

(D) ensure that a continuous effort is made to establish programs which can be of direct benefit to other Native American people.

(3) The Secretary is authorized to enter into contracts with Native Hawaiian organizations for the purpose of assisting the Secretary in meeting the objectives of the demonstration program that is to be established under paragraph (1).

(4) The Secretary shall submit to the Congress an annual report on the status and accomplishments of the program during each of the fiscal years 1988, 1989, and 1990.

(5) There are authorized to be appropriated $500,000 for each of the fiscal years 1988, 1989, and 1990, for the purpose of carrying out the provisions of this subsection.

COMMUNITY HEALTH CENTERS; NATIONAL HEALTH SERVICE CORPS PROGRAM

SEC. 4. (a)(1) The Secretary is authorized—

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(A) to designate Native Hawaiians as a medically underserved population for purposes of section 330 of the Public Health Service Act (42 U.S.C. 254c),

(B) to provide planning grants (no more than 8 and of no more than $100,000 per grant) to Native Hawaiian organizations, or to any organization of health care professionals serving Native Hawaiians, for the purpose of planning community health centers to serve the health needs of Native Hawaiian communities, and

(C) to establish community health centers under section 330 of such Act to serve the health needs of Native Hawaiian communities.

(2) The Secretary shall consult with the Governor of Hawaii regarding any grants that may be made under section 330(c)(1) of the Public Health Service Act (42 U.S.C. 254c(c)(1)), or under paragraph (1)(B), for the planning and developing of community health centers to serve the health needs of Native Hawaiian communities.

(3) In addition to any other amounts authorized to be appropriated for carrying out section 330 of the Public Health Service Act, there are authorized to be appropriated for fiscal year 1987—

(A) $800,000 for the purpose of providing planning grants authorized under paragraph (1)(B), and

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(B) $2,800,000 for the purpose of establishing under section 330 of the Public Health Service Act no more than 8 community health centers to serve the health needs of Native Hawaiian communities,

such sums to remain available until expended, without fiscal year limitation. No more than $350,000 of the funds authorized to be appropriated under subparagraph (B) may be expended for each community health center.

(b) The Secretary is authorized to designate Native Hawaiians as a population group which has a health manpower shortage for purposes of subpart II of part C of title III of the Public Health Service Act.

HEALTH SERVICE SCHOLARSHIP PROGRAM

SEC. 5. (a) Subject to the availability of funds appropriated under the authority of subsection (c), the Secretary shall provide scholarship assistance to students who—

(1) meet the requirements of section 338A(b) of the Public Health Service Act (42 U.S.C. 254l(b)), and

(2) are Native Hawaiians.

(b) The scholarship assistance provided under subsection (a) shall be provided under the same terms and subject to the same conditions, regulations, and rules that apply to scholarship assistance provided under section 338A of the Public Health Service Act (42 U.S.C. 254l).

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(c) There are authorized to be appropriated $1,800,000 for each fiscal year for the purpose of funding the scholarship assistance provided under subsection (a).

HEALTH CARE REFERRAL SERVICES FOR NATIVE HAWAIIANS

SEC. 6. (a)(1) The Secretary shall enter into contracts with Native Hawaiian organizations for the provision of health care referral services for Native Hawaiians. Any such contract shall include requirements that the Native Hawaiian organization successfully undertake to—

(A) determine the population of Native Hawaiians who are, or could be, recipients of health care referral services,

(B) determine the current health status of Native Hawaiians served by the Native Hawaiian organization,

(C) determine the current health care needs of Native Hawaiians served by the Native Hawaiian organization,

(D) identify all public and private health services resources which are, or could be, available to Native Hawaiians,

(E) determine the use of public and private health services resources by Native Hawaiians,

(F) assist such health services resources in providing services to Native Hawaiians,

(G) assist Native Hawaiians in becoming familiar with such health services resources and in utilizing such health services resources,

(H) provide basic health education to Native Hawaiians, including education in health promotion and disease prevention through a community health outreach program that uses Native Hawaiian community health outreach workers,

(I) establish and implement manpower training programs to accomplish the referral and education tasks set forth in subparagraphs (F), (G), and (H),

(J) identify any disparity between the health needs of Native Hawaiians that are not being met and the resources available to meet such needs, and

(K) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of Native Hawaiians.

(2) The Secretary shall prescribe regulations which provide the criteria for selecting Native Hawaiian organizations to enter into contracts under this subsection. Such criteria shall, among other factors, include—

(A) the extent of the health care needs of Native Hawaiians served by the Native Hawaiian organization that are not being met,

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(B) the size of the Native Hawaiian population served by the Native Hawaiian organization,

(C) the accessibility to, and utilization of, health care services by Native Hawaiians served by the Native Hawaiian organization,

(D) the extent, if any, to which the activities that are required to be undertaken under paragraph (1) would duplicate—

(i) any previous or current public or private health services project that was, or is, funded by any means other than a contract entered into under this section, or

(ii) any project funded by means of a contract entered into under this section,

(E) the capability of the Native Hawaiian organization to—

(i) perform the activities that are required to be undertaken under paragraph (1), and

(ii) enter into a contract with the Secretary under this subsection,

(F) the satisfactory performance and successful completion by the Native Hawaiian organization of other contracts entered into with the Secretary under this section,

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(G) the appropriateness and likely effectiveness of conducting the activities that are required to be undertaken under paragraph (1), and

(H) the extent of existing participation, or likely future participation, in the activities that are required to be undertaken under paragraph (1) by appropriate health and health-related Federal, State, local, and other agencies.

(b)(1) The Secretary may enter into contracts under this subsection with Native Hawaiian organizations which have not entered into a contract with the Secretary under subsection (a). The purpose of entering into a contract under this subsection shall be to determine—

(A) the matters described in paragraph (2) in order to assist the Secretary in assessing the health status and health care needs of Native Hawaiians served by the Native Hawaiian organization, and

(B) whether the Secretary should enter into a contract under subsection (a) with the Native Hawaiian organization.

(2) Any contract entered into by the Secretary under this subsection shall include requirements that the Native Hawaiian organization—

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(A) document the health care status and health care needs of Native Hawaiians served by the Native Hawaiian organization,

(B) with respect to Native Hawaiians served by the Native Hawaiian organization, determine the matters described in subparagraphs (B), (C), (D), and (H) of subsection (a)(2), and

(C) complete performance of the contract within one year after the date on which the Secretary and the Native Hawaiian organization enter into such contract.

(c)(1) The Secretary shall include in any contract which the Secretary enters into with any Native Hawaiian organization under this section such conditions as the Secretary considers necessary to encourage the establishment of programs which make health care services more accessible to Native Hawaiians.

(2) The Secretary shall develop procedures to evaluate compliance with, and performance of, contracts entered into by Native Hawaiian organizations under this section. Such procedures shall include provisions for carrying out the requirements of this section.

(3) The Secretary shall conduct an annual onsite evaluation of each Native Hawaiian organization which has entered into a contract under subsection (a) for purposes of determin-

ing the compliance of such organization with, and evaluating the performance of such organization under, such contract.

(4) If, as a result of the evaluations conducted under paragraph (3), the Secretary determines that a Native Hawaiian organization has not complied with or satisfactorily performed a contract entered into under subsection (a), the Secretary shall, prior to renewing such contract, attempt to resolve the areas of noncompliance or unsatisfactory performance and modify such contract to prevent future occurrences of such noncompliance or unsatisfactory performance. If the Secretary determines that such noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract with such organization and is authorized to enter into a contract under subsection (a) with another Native Hawaiian organization that serves the same population of Native Hawaiians which is served by the Native Hawaiian organization whose contract is not renewed by reason of this paragraph.

(5) In determining whether to renew a contract entered into with a Native Hawaiian organization under subsection (a), or whether to enter into a contract with a Native Hawaiian organization under subsection (a) which has completed performance of a contract entered into under subsection (b), the Secretary shall—

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(A) review the records of the Native Hawaiian organization and the reports submitted under subsection (e), and

(B) in the case of a renewal of a contract entered into under subsection (a), shall consider the results of the onsite evaluations conducted under paragraph (3).

(d)(1) No contract entered into under this section may provide for a total amount of payments under the contract by the Federal Government that exceeds $125,000.

(2) All contracts entered into by the Secretary under this section shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provision of the Act of August 24, 1935 (40 U.S.C. 270a, et seq.).

(3) Payments made under any contract entered into under this section may be made in advance, by means of reimbursement, or in installments and shall be made on such conditions as the Secretary deems necessary to carry out the purposes of this section.

(4) Notwithstanding any other provision of law, the Secretary may, at the request or consent of a Native Hawaiian organization, revise or amend any contract entered into by the Secretary with such organization under this section as necessary to carry out the purposes of this section, except

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that whenever such organization requests retrocession of any contract entered into under this section, such retrocession shall become effective upon a date specified by the Secretary that is not more than 120 days after the date of the request by such organization or at such later date as may be mutually agreed to by the Secretary and such organization.

(5) All contracts entered into under this section with Native Hawaiian organizations, and all regulations prescribed under this section, shall include provisions to assure the fair and uniform provision to Native Hawaiians of health care referral services and assistance under such contracts by such organizations.

(e)(1) For each fiscal year during which a Native Hawaiian organization receives or expends funds pursuant to a contract entered into under this section, such organization shall submit to the Secretary a quarterly report on—

(A) in the case of a contract entered into under subsection (b), disparities identified and recommendations made under subparagraphs (J) and (K) of subsection (a)(1),

(B) activities conducted by the organization under the contract,

(C) the amounts and purposes for which Federal funds were expended, and

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(D) such other information as the Secretary may request.

(2) The reports and records of any Native Hawaiian organization which concern any contract entered into under this section shall be subject to audit by the Secretary and the Comptroller General of the United States.

(3) The Secretary shall allow as a cost of any contract entered into under subsection (a) the cost of an annual private audit conducted by a certified public accountant.

(f)(1) The authority of the Secretary to enter into contracts under this section shall be to the extent, and in an amount, provided for in appropriation Acts.

(2) There are authorized to be appropriated $625,000 for each fiscal year for the purpose of funding contracts entered into under this section.

ACCESS TO MEDICARE AND MEDICAID SERVICES

SEC. 7. (a) The Secretary shall, in consultation with Native Hawaiian organizations, conduct a study of any barriers which may exist to the participation of Native Hawaiians in programs established under title XVIII of the Social Security Act (medicare) or under title XIX of the Social Security Act (medicaid).

(b) By no later than the date which is one year after the date of enactment of this Act, the Secretary shall submit to the Congress a report on the study conducted under subsection (a). Such report shall include—

(1) recommendations for legislation which—

(A) would remove any barriers to participation identified in such study, and

(B) would encourage participation by Native Hawaiians in the programs described in subsection (a), and

(2) estimates of—

(A) the potential number of Native Hawaiians eligible for medicare,

(B) the potential number of Native Hawaiians eligible for medicaid,

(C) the number of Native Hawaiians participating in the medicare program, and

(D) the number of Native Hawaiians participating in the medicaid program.

GENERAL AUTHORIZATION

SEC. 8. There are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the provisions of this Act for which a specific authorization of appropriations is not otherwise provided for in this Act.

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Mr. ABDNOR. I am pleased to chair this meeting of the Senate Select Committee on Indian Affairs, since we are holding a hearing on legislation which I introduced to settle all claims against the U.S. arising from the occupation of Wounded Knee in South Dakota on the Pine Ridge Indian Reservation in 1973. This legislation is an outgrowth of a commitment that I personally made over 10 years ago to assist these individuals in obtaining relief for the losses they suffered because of the actions of the American Indian Movement and the Federal forces occupying the area.

In August 1976 the Senate of the United States passed legislation which referred the entire matter of just compensation to the chief commissioner of the U.S. Court of Claims for action. The Court of Claims undertook a detailed review of the events leading up to and including the occupation of Wounded Knee. In 1981 the finding of facts contained in the final decision clearly outlined the need for legislation to compensate the individuals listed in my bill. This bill is a matter of simple justice and compensation owed to these people by the Federal Government.

Senator Inouye, would you have any particular statement on this issue?

STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII

Mr. INOUYE. If I may, I would like to place into the record the statement of the chairman of the committee, Senator Mark Andrews, relative to this legislation, as well as the statement of Senator John Melcher.

Mr. ABDNOR. Without objection. The chairman wanted to be here, but as so often happens, got tied up in other matters.

[Prepared statements of Senators Andrews and Melcher appear in the appendix.]

Mr. ABDNOR. Our first witness today is Ronald Esquerra, Deputy to the Assistant Secretary of the U.S. Department of the Interior here in Washington.

Mr. Esquerra, we welcome you to the committee. We also welcome our other witness, Mr. Ralph Reeser, counsel for the Department. You may proceed, gentlemen, in any fashion you choose.

STATEMENT OF RONALD ESQUERRA, DEPUTY TO THE ASSISTANT SECRETARY FOR INDIAN AFFAIRS (OPERATIONS), U.S. DEPARTMENT OF THE INTERIOR, WASHINGTON, DC

Mr. ESQUERRA. Thank you, Mr. Chairman. I am pleased to be here today to discuss S. 2260.

Mr. ABDNOR. Could we get you to bring the mike a little closer, please?

Mr. ESQUERRA. Is that better?

Mr. ABDNOR. Thank you.

Mr. ESQUERRA. We are pleased to be here today to discuss S. 2260, which is a bill to settle certain claims arising out of activities on the Pine Ridge Reservation. I have a written statement which I presented for the record, and with your permission I will summarize that statement.

Mr. ABDNOR. That will be fine, and without objection, your entire statement will be made a part of the record.

Mr. ESQUERRA. Thank you. The bill essentially is a private relief bill to compensate a number of individuals and businesses for personal injuries or damages to their property during the occupation of Wounded Knee, SD, which occurred between February and May 1973. The bill also provides compensation for services to the Dakota Plains Legal Service.

We oppose enactment of the bill. The plaintiffs have disavowed any claims based upon the legal right of recovery, and instead attempt to build a case in support of a claim for purely equitable relief.

The plaintiffs contended that the U.S. actions or failure to act were responsible for the damages and losses suffered by them as a result of the occupation of Wounded Knee. The contentions of the plaintiffs have been fully investigated and analyzed by the U.S. Court of Claims. The court found that the plaintiffs did not have a basis for equitable claims against the United States.

The court concluded—and quoting from their report—that:

> While it was true that plaintiffs did incur property damages and losses as a result of the occupation of Wounded Knee by militant forces of AIM, the United States should not be deemed legally and/or equitably liable for said damages, since its reaction and response to the occupation was prompt, reasonable, and honorable.

Mr. ABDNOR. What was that last statement? Read that again. What was "prompt, honorable, and reasonable," that last phrase?

Mr. ESQUERRA. It states that:

> While it was true that the plaintiffs did incur property damages and loses as a result of the occupation of Wounded Knee by militant forces of AIM, the United States should not be deemed legally and/or equitably liable for said damages, since its reaction and response to the occupation was prompt, reasonable, and honorable.

Which occurs on page 249 of the report that was filed by the United States Court of Claims.

The court goes on to state that:

> Under such circumstances, any monetary award to the plaintiffs for damages arising out of the Wounded Knee occupation would be a gratuity.

Although the court determined that the monetary damages that these people suffered amounted to about $1,600,000, the findings I have quoted indicate that it is not appropriate for the Federal Government to compensate them.

This concludes my statement. I will be happy to answer any questions that you might have.

[Prepared statement of Mr. Esquerra appears in the appendix.]

Mr. ABDNOR. Sir, when do you feel that something would be justified for compensation? Can you visualize any situation where you had an uprising that maybe the Government should be responsible? Are these people entitled to any kind of protection?

Mr. ESQUERRA. Well, my response would be that the circumstances would dictate any entitlements. In this case, the circumstance and the contentions of the plaintiffs have been investigated and thoroughly analyzed by the Court of Claims, and I must lean to their findings.

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Mr. ABDNOR. Well, of course, I guess in the final analysis it is Congress, because I think in that ruling they also said that it's up to Congress, I think, to make that determination.

But I guess I recall this very vividly. I happened to be in my first year of Congress when this occurred, in the House. I recall situations. I remember particularly one successful rancher, an Indian rancher, who had, I think it was, a 100-cow herd, cow-calf operation, and his home and his family, not too far from this great "DMZ zone" that the Federal Government established and said, "You can't go beyond here."

They were coming to get his cattle. He sent his little boy over to ask for some help, and they told him that they couldn't do it. The cattle were taken and killed. His house was burned. He was lucky to get out of there with his life and his family.

For that kind of a person the Government has no responsibility, and they didn't provide him any kind of protection when he asked for it. I guess it's those kinds of things that have made me feel so strongly about this legislation.

It happened time and time again. I can't imagine what the Federal Government put into this to protect the other side, by having everybody stand around it and make sure nobody bothered them as they went on destroying the property of these people and their livelihood.

I have always been shocked to think that we would even have to go this far to see that they have their just compensation. But again, legislation I guess is before this committee, and in the proper time we will take it under discussion.

Do other committee members have any comments?

Mr. INOUYE. Mr. Chairman, on the case that you cited, are you suggesting that this Indian rancher received no compensation whatsoever?

Mr. ABDNOR. None. Not a cent. I don't even know what's become of the poor man now.

Mr. INOUYE. None for the loss of his herd?

Mr. ABDNOR. None for his cattle, nothing for his home.

Mr. INOUYE. None for his property?

Mr. ABDNOR. None for his property.

Mr. INOUYE. And how did the court conclude under those circumstances that there was "just and honorable" relief?

Mr. ESQUERRA. I am not familiar with the particular individual. In the Court of Claims findings there was a number of contentions as well as a number of plaintiffs listed, and they concluded, as a result of investigating every contention, that the Federal Government should not be legally or equitably liable for the claim that they presented.

Mr. INOUYE. Did any of the claimants receive compensation or redress?

Mr. ESQUERRA. Some of the claimants had private insurance, and they received compensation as a result of their insurance.

Mr. INOUYE. Well, I am not talking about private insurance, I am talking about relief from the Government of the United States of America.

Mr. ESQUERRA. To my knowledge, no.

Mr. ABDNOR. I would like to point out, Senator, if I may, that in most cases it was not the Indians who had this insurance. They were trying to make a living and were doing quite well, and so they were left out. Maybe some of them had insurance, some of the non-Indians. There has been very little for that kind of disaster.

Senator Murkowski.

Mr. MURKOWSKI. Thank you, Mr. Chairman.

I just wonder if the witnesses would give an explanation of the case cited by the chairman and the conclusion drawn in the memorandum to the committee, and I refer to the last sentence, "Finally, the court concluded that any monetary award to plaintiffs for damages arising out of the Wounded Knee occupation would be a gratuity."

It would seem indeed a long ways from the concept of gratuity, the facts of the case thus far as stated by the Senator from South Dakota.

Mr. ESQUERRA. In that particular case, in going back over the comment, the court does not take issue with the fact that property damages occurred by the AIM element that was there. The contention of the plaintiffs was that the Government did not act accordingly, and the findings of the court was that the Government did act in a reasonable, prompt, and honorable fashion.

Mr. MURKOWSKI. Well, Mr. Chairman, obviously there appears to be room for reasonable people to question and doubt, but it would be interesting to know basically what decision based on the obvious human damage that's been done and the lack of any redress.

Mr. ABDNOR. I appreciate that. I certainly think there is that, and having been so close to the situation, it's just difficult for me to realize that we had our Government people surrounding this area and refusing to let any kind of police protection in there. As you might guess, it was those creating the rebellion that came out best.

I can't remember the man's name. After all, this was 11 years ago. He had a little trading post down there that was totally destroyed. And I remember the press was there and the TV cameras took pictures of it as they were doing it. They were carrying things out, right in front of the cameras. The darndest thing I've ever seen. Then you tell me this poor guy is not supposed to be compensated. I can't think of his name, but I assure you his account is in there.

Mr. INOUYE. This happened on the reservation?

Mr. ABDNOR. Yes; Pine Ridge. We have just never been able to bring it to the forefront. We are now, and I assure you next week we will have markup on this legislation.

If there is no further comment on this, we will then turn to our next witnesses and our consideration of S. 2243.

Mr. INOUYE. Mr. Chairman, I have a statement of the chairman of this committee, Senator Mark Andrews. If I may, for the record I will read this.

We will now turn to S. 2243, a bill to improve the health status of native Hawaiians. I am pleased to be a cosponsor of this bill along with Senator Inouye, the senior Senator from Hawaii, and Senator Melcher, the ranking minority member of the committee.

S. 2243, a bill to improve the health status of Native Hawaiians, represents the response of the Congress to the findings of a study of the health care needs of

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Native Hawaiians that was authorized in the 1984 supplemental appropriations act. The study was conducted by health care providers and professionals in the State of Hawaii on a voluntary basis. The study was submitted to the Department of Health and Human Services in December of 1985 and fully documents the pressing needs for special initiatives to address the health care needs of Native Hawaiians.

This bill, S. 2243, authorizes a comprehensive approach to raising the health status of Native Hawaiians through the establishment of a health promotion and disease prevention program and also authorizes additional appropriations to expand the existing community health center program. It also provides for the inclusion of Native Hawaiians in a national health service corps scholarship program.

In my view, this bill is a sound and critical investment in the future of the Native Hawaiian population."

This is the end of the chairman's statement. If I may, Mr. Chairman, I have my own statement, but in view of the time element, without objection, may I request that my statement be made a part of the record?

Mr. ABDNOR. Without objection, it will be made a part of the record.

[Prepared statement of Senator Inouye appears in the appendix.]

Mr. INOUYE. Mr. Chairman, if I may, I would like to present to you the first witness on this legislation. Our first witness is Hawaii's illustrious Congressman, the Honorable Daniel Akaka.

Mr. ABDNOR. Congressman Akaka, welcome, sir.

STATEMENT OF HON. DANIEL AKAKA, MEMBER OF CONGRESS FROM HAWAII

Mr. AKAKA. Thank you very much, Senators and Mr. Chairman. I am delighted to be here before the members of the Select Committee on Indian Affairs, and I thank you for this opportunity to testify in support of S. 2243, to improve the health status of native Hawaiians.

Since the absorption of Hawaii into the social, cultural, and political life of the West, the indigenous inhabitants of that land, the native Hawaiians, have been plagued with the fate of rapid depopulation. When Capt. James Cook first discovered the islands in 1778, the population was nearly 300,000 Hawaiians. Fifty years later, when the missionaries took count, the population had dwindled to 142,000 Hawaiians. A still further decrease to 41,000 was recorded by the census of 1890. Today, pure Hawaiians number somewhere in the vicinity of 9,000. Sadly, they join hands with their part-Hawaiian descendants as a dwindling people in their own land.

Native Hawaiians, who represent between 12 and 19 percent of Hawaii's total population, have the highest age-sex standardized mortality rates, the lowest life expectancy rates, the highest rate of infant mortality, the greatest risk of diabetes and heart disease in the entire State, and one of the highest cancer rates of any population in the United States—this in addition to the fact that their incomes are the lowest in the State, the size of their families is the largest, and that they have suffered the greatest difficulty in assimilating to the practices of modern Western medicine.

Health care assistance for native Hawaiians is needed, Mr. Chairman, now. S. 2243 not only recognizes this need but also fills in the health status abyss now known to native Hawaiians.

Congress has seen fit to pass numerous legislative enactments designed to benefit native Hawaiians in education and employment.

Such enactments are envisioned as unprecedented gains by the native Hawaiian community. Nevertheless, for what purpose should we entertain the thought of educational and economic success for that community if its viability and outright existence cannot be ensured?

Indeed, among the most important and effective means of ensuring the success of native Hawaiians in becoming well-adjusted and productive members of society is through health care. S. 2243 superbly addresses this need in providing the means through which the health status of native Hawaiians may be improved. I offer, Mr. Chairman, my wholehearted support to this most important and long-overdue measure.

I also want to commend Senator Inouye and his staff for their splendid work in fashioning this very important bill for the Hawaiians.

Mr. Chairman and members of the committee, I thank you for your attention and for your sincere interest in this matter. Thank you very much.

Mr. INOUYE. Thank you very much, Congressman Akaka. It may interest you to know that because of the urgency of this matter, the committee will have a markup of this bill on May 13.

Mr. AKAKA. I assure you also, Mr. Chairman, that I will be very happy to work on the other side with you.

Mr. INOUYE. I thank you very much.

Senator Gorton.

Mr. GORTON. Thank you very much. We appreciate your bringing this to our attention, and I am happy that the Congressman is here to develop our understanding of the issue.

Mr. INOUYE. Thank you very much.

Mr. AKAKA. Thank you.

Mr. INOUYE. Our next witness is the Honorable Cecil Heftel, Member of the House of Representatives, representing the State of Hawaii. Congressman Heftel will be soon leaving the House to pursue another position.

We wish you well, sir.

STATEMENT OF CECIL HEFTEL, MEMBER OF CONGRESS FROM HAWAII

Mr. HEFTEL. Thank you, Senator Inouye. I would like to ask unanimous consent to revise and extend my remarks and to summarize the prepared testimony.

Mr. INOUYE. Without objection, your full statement will be made part of the record.

Mr. HEFTEL. I want to congratulate the Senator for having initiated this legislation and certainly to welcome those who ahve come from Hawaii to testify on behalf of S. 2243.

Because I came to Hawaii in about 1960 and then permanently located in Hawaii in 1964-65, I have a perception of the native Hawaiian people which I think is what we'd have to term painful at best. They are a people who have been displaced in their own land.

The health problems that they exhibit are what you expect from a people who are displaced, who are frustrated: alcoholism, obesity, heart disease, stress, stress manifestations, and the U.S. Govern-

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ment has a responsibility. The Government recognizes this to a limited degree in some economic and educational forms. But overall, including their health needs, the Hawaiian people are owed a concern and a redress of the problems that they have to try to confront in a society from which they have been estranged.

Hawaiians are basically not a competitive people in the sense that mainland America is competitive. The capitalistic system is something that they don't really relate to. They don't know how to compete for food against someone else, to compete for shelter against someone else, to even compete for their land against someone else.

They have been taken advantage of because they haven't known or understood the rules of the game. They still think in terms of the open door and the open kitchen and the open society, the family of men and women as a totality as opposed to competitive individual family units. We are just beginning to touch the problems that they have been confronted with since Hawaii became a territory, and most certainly and specifically since Hawaii became a State.

I cannot too strongly recommend that the committee go forward with Senator Inouye's bill, that we pursue the same legislation on the House side, but more important, that we also address the fact that these problems exist because of what happened to the Hawaiian people when America took over their land.

They do not know how to conduct themselves in the heritage and culture of their people. They don't know how to live off of the land anymore because we have deprived them of the method of doing so. The physical ills which they exhibit must be addressed as physical ills, with an understanding of the underlying social problems, economic factors. Hopefully, there will be a way ultimately to put together the problems that are economic, that are social, that are educational, and physical well-being, and that the Federal Government will endeavor to address those problems in a unit rather than separate parts, look upon the Hawaiian people as people who have been abused, and try to seriously address those problems. I cannot too strongly recommend that this be the beginning of something that has not yet occurred in terms of a sense of responsibility and effectiveness on the part of our Federal Government in addressing the problems of our Hawaiian people.

Again, Senator, I commend you for this legislation.

Mr. INOUYE. I thank you very much, Congressman Heftel. It may interest you to know that this measure is being cosponsored by the chairman of this committee and by the ranking minority member.

Mr. HEFTEL. That is a very good recommendation for its passage.

Mr. INOUYE. I think it will pass, sir. Thank you very much, sir.

Mr. HEFTEL. Thank you.

Mr. INOUYE. Before proceeding, without objection, the statement of the ranking minority member, Senator John Melcher, will appear in the record following that of the chairman of this committee, Senator Andrews.

Our next witness is the Deputy Assistant Secretary for Health of the U.S. Department of Health and Human Services, Dr. Sam Lin.

Dr. Lin, welcome, sir.

STATEMENT OF SAMUEL LIN, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH (INTERGOVERNMENTAL AFFAIRS), U.S. PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. LIN. Good afternoon. It is a pleasure for me to appear before you to discuss the health of native Hawaiians and the proposed S. 2243. Let me start by assuring you that the Public Health Service continues to work closely with the Hawaiian Department of Health and other health providers to advance the health of all Hawaiians. We believe that the State of Hawaii has the one of the finest departments of health in this country, and the statistics of the Hawaiian people will attest to that fact. The residents of Hawaii have the highest life expectancy in this country and the lowest infant mortality rates.

The Public Health Service is opposed to S. 2243 because it would lessen the responsibility of the Hawaiian Government for its own people and further remove the decision making from the local communities.

We believe that the recently formed Native Hawaiian Health Planning Advisory Committee and the concomitant development of the E Ola Mau, or the Preliminary Plan for Improving Native Hawaiian Health Through Health Promotion, Disease Prevention, and Health Protection, is a more constructive approach to raising the level of the health status of native Hawaiians and to encourage their maximum participation in the planning and management of their own health services.

Mr. Chairman, aside from our other objections to S. 2243, we believe that the provisions dealing with the community health centers and National Service Corps scholarships are unnecessary and redundant.

The authority to designate medically underserved populations already exists in section 330 of the Public Health Service Act. It is not necessary to restate that authority for native Hawaiians. In fact, we have already designated 14 medically underserved areas in the State of Hawaii.

The authority to fund new CHC's also is contained in section 330 of the Public Health Service Act, and we do make such awards within the limits of available resources. Awards are made to community-based systems of care which demonstrate the ability to provide access to medically underserved populations. These systems must have effective clinical operations and efficient administration and management.

Similarly, the authority to designate populations as having a health manpower shortage exists in section 332 of the Public Health Service Act. Designation is based on the ratio of available health manpower to the number of individuals in the area or population and on the indicators of need such as infant mortality and poverty. There are currently two primary care health manpower shortage areas designated in Hawaii.

There are several student assistance programs available for Hawaiians who wish to pursue health careers, including the health education assistance loans, the health professional student loans, and the nursing student loans.

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In summary, we believe that the intent of the proposed legislation can be best accomplished with existing authorities and programs and resources and by placing the responsibility for the health of undeserved with themselves, with their own communities, and with the State of Hawaii.

Mr. Chairman, this concludes my prepared statement, and I would be happy to answer any questions.

Mr. INOUYE. What would your response be if, instead of "Native Hawaiians," we had "the Sioux tribe"? To put it more precisely, American Indians are considered native Americans, and the laws of the land consider native Hawaiians to be a special part of this country wherein we exercise special responsibility. This committee has looked upon native Hawaiians as native Americans and, as a result, they have qualified for special scholarship programs.

Dr. LIN. Our position is that we already have the basic authority to do what is proposed by this bill.

Mr. INOUYE. Would you apply the same rule for the Cherokees, the Hopis, and the Navajos?

Dr. LIN. We have other legislative mandates under which we operate those programs.

Mr. INOUYE. As native Americans?

Dr. LIN. Yes, sir.

Mr. INOUYE. If Hawaiians are native Americans, should they be treated like other native Americans?

Dr. LIN. Well, I believe, again, our intent is that we are able to do essentially what is proposed in S. 2243 as opposed to adding additional laws and regulations and policies.

Mr. INOUYE. Well, I better not notify the Indians of this change of attitude. They may not like this, but we will take the matter under consideration. We thank you for your testimony, sir.

Dr. LIN. Thank you, sir.

Mr. INOUYE. Thank you very much.

Our next witness is the chief of the Mental Health Division of the Hawaii State Department of Health, Dr. Denis Mee-Lee.

Doctor, welcome.

STATEMENT OF DENIS MEE-LEE, M.D., CHIEF, MENTAL HEALTH DIVISION, HAWAII STATE DEPARTMENT OF HEALTH, HONOLULU, HI, ACCOMPANIED BY JAMES McTIGUE, M.D.; AND LARRY SAUER

Dr. MEE-LEE. Senator Inouye, I am very pleased to be here today and speak as the acting deputy director of health for medical matters as well as chief of the Mental Health Division for the State of Hawaii. I might mention that I am also associate professor in the school of medicine of the University of Hawaii. I am pleased today to read the prepared testimony of the director of health, Leslie Matsubara.

The Hawaii Department of Health is truly appreciative of this opportunity to testify in support of S. 2243, a bill to improve the health status of native Hawaiians. The findings of this bill outline some of the astounding realities regarding the health status of native Hawaiians. Accumulating data has convincingly confirmed

the validity of these growing concerns about the extent of unique problems within this special population.

Cast in the backdrop of Hawaii's general population, which usually compares positively on most health indicators, native Hawaiians fare poorly over a wide spectrum of physical, emotional, social, and functional dimensions. Although the department has recognized many aspects of these unique health problems in the past, it has not been easy to assemble the relevant and effective prevention and intervention approaches or necessary resources to tailor a concerted effort on behalf of the native Hawaiian population.

Several significant pilot and demonstration projects have been initiated by the department, with some successful results. However, we recognize that much more needs to be done. From the public health perspective, our fundamental concern is that without a more widespread and concerted communitywide effort, there is a real potential for perpetuation and intensification of these problems, affecting many dimensions of life for native Hawaiians and the population of our State generally.

For these reasons, the Hawaii Department of Health strongly endorses this bill which clearly seeks to achieve a major and broad impact upon native Hawaiian health problems.

We make two recommendations: First, while we agree that native Hawaiian organizations should be the primary participants in carrying out the proposed activities of this bill, we recommend that an appropriate State government entity be designated to oversee and administer these grants. The Hawaii Department of Health is willing to play whatever role would be helpful.

The reasons for this recommendation are as follows: This is a far-reaching statewide effort with much potential for public implications and accountability, and therefore, oversight should be located within a State governmental agency. This local, centralized oversight arrangement would allow the participation of various native Hawaiian organizations. Because of the developmental, educative, training and evaluative aspects of these grants, the University of Hawaii, such as the school of medicine or possibly the school of public health, should be involved for its clinical and scientific expertise and opportunities to interchange technical knowledge with other relevant universities throughout the country.

The second recommendation: The act should require the formation of an advisory board to the grantee or grantees, representative of all interested parties in Hawaii, for purposes of assisting the appropriate development and progress of these projects.

The Hawaii Department of Health urges the Committee on Indian Affairs' support of S. 2243 and offers its assistance in whatever ways to assist Congress to achieve the purposes of this bill. Thank you very much.

[Prepared statement of Mr. Matsubara appears in the appendix.]

Mr. INOUYE. Thank you very much.

Doctor, are you convinced that the native Hawaiians have unique health problems?

Dr. MEE-LEE. Absolutely, sir. The data that is accumulating and the studies that we and others have done within the State indicate substantial health—physical and mental—and social problems amongst native Hawaiians.

Mr. INOUYE. Now, has the State of Hawaii adopted special programs to address these unique health needs?

Dr. MEE-LEE. I believe the State, through the Department of Health and through other entities public and private, have periodically attempted to address these unique needs, with variable success. As I mentioned in the testimony, the problems of pulling together appropriate approaches as well as necessary resources have generally seemed to hinder an adequate response to these problems.

Mr. INOUYE. Thank you very much.

Dr. MEE-LEE. Thank you, sir.

Mr. INOUYE. Our next witness is the chief executive officer of Alu Like, Inc., Ms. Winona Kealamapuana Ellis Rubin.

STATEMENT OF WINONA KEALAMAPUANA ELLIS RUBIN, CHIEF EXECUTIVE OFFICER, ALU LIKE, INC., ACCOMPANIED BY ORMOND HAMMOND, PH.D., DIRECTOR, PROGRAM EVALUATION AND PLANNING, THE KAMEHAMEHA SCHOOLS, BISHOP ESTATE, HONOLULU, HI; NOA EMMETT ALULI, M.D., MOLOKAI HEART STUDY, KONA-KAUNAKAKAI, HI; CLAIRE HUGHES, CHAIRPERSON, COMMITTEE ON HEALTH CONCERNS, ASSOCIATION OF HAWAII CIVIC CLUBS, HONOLULU, HI; AND NALEEN ANDRADE, M.D., PSYCHIATRY DIVISION, QUEENS HOSPITAL, HONOLULU, HI

Ms. RUBIN. Senator Inouye, members of the committee and staff, I am Winona Kealamapuana Ellis Rubin, and on behalf of the people in Hawaii, the Hawaiians, particularly, the panel, the consortium, and those who will be benefitting from this legislation, we wish to express our appreciation, Senator Inouye, to you and to Senator Melcher and Senator Andrews for the introduction of S. 2243 and for the opportunity for this panel to make its presentation today. Mahalo A Nui Loa. Thank you.

I would like to begin with the introduction of the panel, and if we may depart from the order in which they are listed currently, we would like to revise that order of presentation. I will introduce them in the order in which they will present: Dr. Ormond Hammond, who is director of program evaluation and planning at the Kamehameha Schools. His focus will be on the strategic health plan task force report. He will be first to present.

After him will be Dr. Noa Emmett Aluli, a physician on Molokai, who will present the information from the historical/cultural task force report.

Following him will be Mrs. Claire Hughes, public health nutritionist, and her area of focus will be the nutrition/dental health task force report.

Dr. Naleen Andrade, chief psychiatry resident at the University of Hawaii, Manoa School of Medicine, will focus her presentation on the mental health task force report.

Although each panel member is focusing on the task force report on which he or she was a member, the speakers have included some comments which reflect the point of view of their organizations and Hawaiian constituency.

Mr. Chairman, may we request that our written testimony and appendixed material be included in the record of these proceedings?

Mr. INOUYE. Without objection, it will be done.

Ms. RUBIN. Thank you. If I may begin my testimony with a brief reference to Alu Like. Alu Like is a private, nonprofit community-based organization of over 15,000 members of Hawaiian ancestry, and Alu Like administers the native Hawaiian programs established under title VIII of the native American Programs Act. It provides the enabling mechanism for promoting the goals of economic and social self-sufficiency for native Hawaiian clients.

As part of our continuing effort to meet the needs of the native Hawaiian community, Alu Like has investigated the health needs in the native Hawaiian population and has formed and coordinated the native Hawaiian Health Research Consortium to address these needs. This consortium includes members from native Hawaiian institutions and agencies and from public and private research, educational, and health institutions and agencies.

The consortium has completed a native Hawaiian health needs study report, E Ola Mau, which was prepared for the Department of Health and Human Services in response to a request from the Senate Appropriations Committee. The scope of the report focused on five task force areas; namely, medical, mental health, nutrition/dental health, historical/cultural, and strategic health plan. It is from the perspectives of these task forces that members of this panel will present their testimonies.

I will be addressing section 3 of this bill pertaining to health promotion and disease prevention, section 4 on community health centers and National Health Service Corporation programs, and section 7 on access to Medicare and Medicaid services, from the perspective of the medical task force. As I indicated earlier, others on this panel will be addressing the remaining portions of the bill.

Section 3 states, "The Secretary, shall in consultation with native Hawaiian organizations, establish a program of health promotion and disease prevention designed to serve the native Hawaiian population." It further specifies that this program shall "provide necessary preventive-oriented health services, including maternal and child health care and mental health care."

This comprehensive approach to preventive programs will conserve limited financial and personnel resources, since it will reduce the number of serious health problems in the native Hawaiians population through early detection and therapy.

The provision in section 3(b) for the collection of data related to the prevention of diseases and illnesses among native Hawaiians—including fetal, alcohol syndrome, hypertension, heart disease, and diabetes—is important, since at present the measures of incidence and prevalence of these illnesses is not adequate. This is also important, since the establishment of baseline data is the only way the effectiveness of preventive programs can be determined. Also, the prioritization of programs shall be based upon adequate incidence/prevalence data.

The collection of data can be accomplished through sample surveys, screening programs, and other surveillance in cooperation with providers of health services. Additional research can study the

risk factors associated with these diseases. This will optimize the resource expenditures, since services can be offered and established in areas where native Hawaiians at high risk are located.

Evaluation of intervention can be made along with the provision of services in order to determine the effectiveness, cost-benefit ratios, changes in quality of life, and other factors as the preventive programs are implemented.

Section 3(c) includes a provision for medical and general health-related research into diseases that are most prevalent among native Hawaiians, including but not limited to heart disease, hypertension, cancer, diabetes. These are the most prevalent diseases among native Hawaiians, and the native Hawaiian experiences greater prevalence in these diseases than do other groups, and I am referring to attachment 2.

It is important to improve the available data on incidence and prevalence of the illness in order to establish priorities and to conduct research on risk factors in order to plan preventive programs. It is also important to have ongoing monitoring and surveillance on various diseases in order to evaluate progress in preventive programs in order to reassess priorities.

The establishment of ongoing data collection and research allows for continuous monitoring of effectiveness as well as changes in prevalence patterns, which can be the basis for establishing priorities and planning implementation of services.

Regarding section 4 on community health centers and the National Health Service Corporation Program, the consortium recognizes the need to stimulate existing private and public health care delivery systems to more effectively respond to the health needs of native Hawaiian clients. Private sector medicine will increase its responsiveness as more native Hawaiians enter the health professions. This requires a systematic effort to recruit and train native Hawaiian medical candidates and to assist them in establishing practices in Hawaiian communities.

Local professional associations, educational institutions, and voluntary agencies provide often-untapped resources. Existing Federal programs such as the National Health Service Corps can be utilized to maximize educational opportunities for native Hawaiians and to effectively relocate medical manpower in high-need Hawaiian communities.

American Indians in Alaska, Eskimos, are already designated as a health manpower shortage area population group. This bill would recognize native Hawaiians as a health manpower shortage area population group as well.

It should be recognized that unique and significant health problems do exist in many Hawaiian communities. In such areas, where there is a shortage of health manpower or large uninsured populations or where extensive health problems exist that require a comprehensive intervention strategy, new health resources must be developed.

In reviewing potential models for augmenting existing health resources, the consortium supports the use of community health center programs under Public Health Service section 330. The community health center program offers the following advantages:

One, it is predominantly community-based, enabling a high degree of local autonomy; two, it maximizes the potential of public and private resources, including volunteers; three, it has gained bipartisan support in both Houses of Congress, has recently received congressional reauthorization, and has retained a high degree of stability even in difficult budget periods; four, it has proved to be a highly efficient program which has leveraged services valued at more than twice as much as the Federal grant funds involved.

In order to adapt PHS 330 funding criteria to Hawaii, Hawaiian geographic conditions must be considered. Entire islands are often a single census tract. This bill allows for medically underserved area designation for native Hawaiian communities, enabling them to seek 330 funds.

This bill can, for a modest investment, go a long way to improve the health status of native plans. It can do so efficiently by tapping both private and public resources, utilizing existing channels of Federal support, and by cultivating the creative energies inherent in local native Hawaiian communities. This legislation will give native Hawaiians the opportunity to develop resources and maintain responsibility for their own health.

Section 7, regarding access to Medicare and Medicaid services, states that:

> The Secretary should, in consultation with native Hawaiian organizations, conduct a study of any barriers which may exist for the participation of native Hawaiians in programs established under Title XVIII of the Social Security Act (Medicare) or under Title XIX of the Social Security Act (Medicaid).

In order to increase the accessibility of these programs to native clients, it's important to understand why there are barriers which prevent native Hawaiians from participation. This can be achieved by understanding Hawaiian cultural values and perceptions of native Hawaiians regarding not only accessibility but availability and acceptability of services.

It is also important to investigate ways in which these barriers can be ameliorated. This can best be done through demonstration projects which can test various means of improving access.

From the scant data on Medicare and Medicaid participation available for native clients, they seem to participate less than the general population. Research on the extent and types of third-party insurance coverage as well as Medicare and Medicaid participation will facilitate planning for improved access to medical services. Further research can study the number of native Hawaiians who participate in, as well as the potential number of native Hawaiians who might participate in, Medicare and Medicaid Programs. This allows program planners to determine the resources necessary to meet current demand as well as potential demand for services.

Finally, this bill specifically targets Federal investment in native Hawaiians and consistent with past practices and our concern for fellow native Americans, it in no way jeopardizes or dilutes the funds and resources already going to other native American groups.

I thank you very much for the opportunity to present this report, and the panel continues in order of the introduction.

[Prepared statement of Ms. Rubin appears in the appendix.]

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Mr. INOUYE. Our next witness is Dr. Ormond Hammond, director of Program Evaluation and Planning, at the Kamehameha School.

STATEMENT OF ORMOND HAMMOND, DIRECTOR, PROGRAM EVALUATION AND PLANNING, THE KAMEHAMEHA SCHOOLS, BISHOP ESTATE

Dr. HAMMOND. Thank you, Senator Inouye. My name is Ormond Hammond. I am a psychologist as well as being director of Program Evaluation and Planning at the Kamehameha Schools, Bishop Estate. I also served as a member of the Strategic Plan Task Force of the native Hawaiian Health Needs Study, the E Ola Mau. The purpose of my testimony today is to review the recommendations of this most comprehensive study to date of native Hawaiian health needs and, in so doing, offer support for S. 2243.

Although the primary mission of the Kamehameha Schools Bishop Estate is education, our studies have indicated that multiple physical and mental health problems, apparently related to loss of native culture, do adversely affect academic outcomes for Hawaiian students. These findings have been confirmed by the more recently completed native Hawaiian Health Needs Study.

In our written testimony and other presentations today you will find ample evidence for native Hawaiian health needs. I want to cover the recommendations of the study, the priorities that were identified.

In the various task force reports, some 74 separate recommendations are made. In the Strategic Plan Report these are summarized into a coordinated system of six priority components. Now, what are these six components and how are they addressed by S. 2243?

The first recommendation of the study is for a Health Research and Surveillance Component. Throughout the study, the need to better understand the causes of the poor health status of native Hawaiians was emphasized. In addition, better surveillance data are needed in order to properly monitor and evaluate program effectiveness.

There are several provisions in S. 2243 which would permit the development of just such needed research and surveillance. Specifically, section 3 calls for the collection of data related to the prevention of disease, for medical and health-related research, and for mental health research. In section 6 there is also a call for the collection of data which would facilitate the evaluation of program effectiveness.

Second, all of the task forces emphasized the need to have traditional native Hawaiian values, practices, and healers at the forefront of efforts to improve Hawaiian health. Provisions of S. 2243 would permit the development of programs which fully integrate traditional Hawaiian values with needed intervention. This can be accomplished through cooperative efforts by native Hawaiian organizations, each of which has developed effective strategies for incorporating Hawaiian culture, beliefs, and human resources into its programs.

Third, it is recommended in the reports that appropriate and responsive health care be provided directly to native Hawaiian communities through the community health center model. This recom-

mendation is exactly what is contained in S. 2243, section 4. This will permit native Hawaiian communities to develop responsive and community-based health services.

The fourth recommendation of the study is for a Health Promotion Component. Perhaps the most pervasive theme throughout the study was the need for preventive and educational efforts. Seen as being important causal factors of poor overall health status among native Hawaiians was lack of knowledge of good health habits, understanding of risk indicators, and the need for culturally appropriate habit and life-style change programs. S. 2243 again addresses this primary recommendation throughout section 3.

The fifth recommendation of the study is for a Professional Health Training Component. Native Hawaiians are seriously underrepresented at this point in time in all health professions. In section 5 of S. 2243 this need is directly addressed through the health service scholarship program.

This section is of particular interest to us at the Kamehameha Schools because we conduct a scholarship program, a limited one, for native Hawaiian students pursuing postsecondary education in Hawaii. It has been our experience, and we feel strongly, that scholarship aid of this type can significantly increase the numbers of native Hawaiian health care professionals.

Finally, the health study emphasizes the need to coordinate and oversee efforts on behalf of native Hawaiian health improvement. This central Health Planning and Monitoring Component should involve the State Department of Health as well as other major agencies and institutions impacting upon native Hawaiian health. By providing management development grants for native Hawaiian organizations, one objective of which is health planning, section 3 of S. 2243 will enable this recommendation to become a reality.

In short, and the major point I wanted to make, is that all of the priority recommendations of the health study are covered by S. 2243.

Senator, I would like to thank you and the other members of your committee for this opportunity to testify on behalf of S. 2243. I want to assure you that the Kamehameha School stands ready to fully participate, along with our sister agencies at the State and local level, in all efforts for the benefit of native Hawaiians. We remain convinced that, through these kinds of joint efforts, the day will come, and in the not-too-distant future, when the history of the native Hawaiian population will truly be considered a success story.

[Prepared statement of Dr. Hammond appears in the appendix.]

Mr. INOUYE. Thank you very much, Dr. Hammond.

Our next witness is Dr. Noa Emmett Aluli, of Molokai.

STATEMENT OF NOA EMMETT ALULI, M.D.

Dr. ALULI. Mr. Chairman, Senator Daniel Inouye, members of the Select Committee on Indian Affairs, especially the staff, Aloha. I have a corrected copy of my written testimony, with just some typographical corrections.

Mr. INOUYE. Without objection, your statement will be made part of the record.

Dr. ALULI. Thank you. My name is Noa Emmett Aluli. I am part of the first graduating class of 1975 of the University of Hawaii School of Medicine. I have done all of my medical training in Hawaii except for 9 months at the University of Rochester, in urology, and also for 2 months at the University of New Mexico, in nephrology.

I speak on behalf of myself as involved in primary care medicine for 10 years on Molokai. I speak for a grass-roots group, nonprofit organization dedicated to the betterment of the health conditions of native Hawaiians, called Na Puuwai. I speak on behalf of a consortium, a hui, of native Hawaiian health professionals, an islands-wide group called E Ola Mau. I also speak on behalf of many grass-roots native Hawaiian community organizations throughout Hawaii.

I wanted to begin my testimony by explaining one of the attachments I have made to my written testimony. It is a new kind of graph analysis that really points to the current status of the Hawaiians' death rates. You know, the native Hawaiian population was devastated by epidemics of infectious disease to which we had no immunity in the first years of contact with Western man. Today the life expectancy of native Hawaiians remains the lowest of all ethnic groups in Hawaii due to a new set of diseases for which we seem to have a greater propensity than the industrialized societies where these diseases were first noted in epidemic proportions.

Vital statistics data indicate pure Hawaiians have over two, almost three, times the death rate for cardiovascular diseases than the rest of Hawaii's population. If one compares the number of deaths in Hawaiians to that of Caucasians in Hawaii, there are proportionately more Hawaiians dying each year in all age groups.

The proportion of deaths in Hawaiians which is over and above that occurring in Caucasians can be thought of as excess deaths. If we examine the causes of these excess deaths in Hawaiians, we find that in those 45 to 64 years of age, where the highest death rates occur, that over half of these deaths are due to cardiovascular diseases. And I have enclosed a pie-shaped graph for your review.

I want to switch from my written testimony and talk about Molokai, because Molokai epitomizes the native Hawaiian problems with health care. If you remember March 24, 1986, Time magazine, the cover was, "Sorry, America your insurance has been cancelled." The lead paragraph in this feature cover story on the Nation begins, and I quote:

> On the Hawaiian island of Molokai pregnant women who want a doctor in attendance when they give birth fly to neighboring Oahu or Maui. The five Molokai doctors who once delivered babies have stopped doing so because malpractice insurance would cost them more than the total of any obstetrical fees they could hope to collect.

Molokai, where at one time historically all the Kahunas from all the islands gathered to try to save the Hawaiian culture, religion, and traditional practices; Molokai, where Father Damien died after caring for the lepers; Molokai, where the Hawaiian Homes Program started just two generations ago for the 50 percent native Hawaiian blood quantum; Molokai, where pineapple, Dole and Del Monte, have finally pulled out and the Molokai Ranch is now bankrupt; Molokai, where unemployment is almost as high as 18 per-

cent; Molokai, where Medicare and Medicaid population ranges from between 37 to 43 percent and where the State gives the primary providers of medicine the lowest profiles and the lowest reimbursements for health services; Molokai, where the cattle is being exterminated because of questionable tuberculosis; Molokai, where our only community hospital is suffering from bankruptcy; Molokai, where Na Puuawai begins to try to correct things in a real Hawaiian way with families and self-help programs; Molokai, where we're fortunate enough to begin working with funds that came from the World Health Organization and funds that come from the School of Public Health and funds that come from the Hawaii Heart Association and funds that will be coming from Straub Clinic and, hopefully, Office of Hawaiian Affairs, where we can do a statistical analysis, which I outlined, to study the current risk factors of cardiovascular disease, of diabetes, of renal failure—so that we can best begin educating our families and begin doing self-help programs for the betterment of the native Hawaiians.

The Molokai heart studies will be well recognized. We are in the process of one-to-one consultations with the 260 participants. We have planned a phase II of the Molokai heart study this summer which will bring new data to currently show the problems in the native Hawaiian communities. This phase II will move out of the Hawaiian homestead areas and begin measuring, looking for risk factors amongst the native Hawaiians who live toward the ocean, toward the east of Molokai.

We also hope to get a grant that would compare traditional diets to the current Hawaiian diets of canned foods.

In summary, Mr. Chairman, my testimony is one that feels that native Hawaiians need more than just funds and programs to better their conditions, and we need to address this in a broader and more cultural perspective. I work on Molokai, we know for sure, and it is our hypothesis, that the 50 percent blood quantum suffer more from the chronic diseases mentioned in the studies presented today. On Molokai we strongly disagree with the bill as it defines the native Hawaiian organization: We believe that a native Hawaiian organization should be one primarily composed of native Hawaiians. We also question why the bill signals out the Governor's approval of a native Hawaiian organization before these programs can be carried out.

In conclusion, on behalf of the group of native Hawaiian health professionals, I want to state again that we would like assurances that whatever native Hawaiian organizations that the Secretary would enter into agreements with are, first, representative of the native Hawaiians, second, are representative of the native Hawaiian health professionals, and third, are truly representative of the native Hawaiian community needs.

Mr. Chairman, I thank you, and I am open to any questions. Mahalo.

[Prepared statement of Dr. Aluli appears in the appendix.]

Mr. INOUYE. I am certain the intent of this bill is to work closely and coordinate all activities with the native Hawaiian organizations. But someone or some agency must have the responsibility of determining the existence of such native Hawaiian organizations.

Can you think of any other agency other than the Governor's office?

Dr. ALULI. Mr. Chairman, this is something that I hope that when we get back to Hawaii we could really work through before the markup. It's hard for us on Molokai to look at all our problems and to see who solves those problems for us. And it has not been the State. And we can look historically back and at all the different problems with the heptachlor and with closing of the leper home in Kahihi, and we can look back and see that the State has not been responsible, and the conditions for native Hawaiians continue to date.

We look for that other organization, whether it's the Office of Hawaiian Affairs, whether it's Alu Like, whether it's the group of native Hawaiian health professionals, E Ola Mau, whether it's a combination of the State and University of Hawaii School of Medicine. I think there needs to be an opportunity to keep State politics out of health improvements for the native Hawaiians because I don't think that we will be able to improve ourselves unless we get, from the bottom up, the foundation that's very important, Mr. Chairman.

Mr. Inouye. Under your definition, would you disqualify the School of Medicine at the University of Hawaii?

Dr. ALULI. As a native Hawaiian organization, Mr. Chairman, as defined——

Mr. INOUYE. As a participating organization.

Dr. ALULI. No; but as a native Hawaiian organization, certainly.

Mr. INOUYE. Alu Like is qualified?

Dr. ALULI. Yes; Alu Like is a native Hawaiian organization because their board is primarily—almost 100 percent, I believe—composed of native Hawaiians.

Mr. INOUYE. Would OHA qualify?

Dr. ALULI. OHA, you've got to be a Hawaiian to be a trustee. They are a native Hawaiian organization.

Mr. INOUYE. Would the Kamehameha Schools qualify?

Dr. ALULI. I think their board—surely their students are majority native Hawaiians.

Mr. INOUYE. What organizations won't qualify of the ones that are being considered?

Dr. ALULI. Well, I don't think we've gotten down to the nuts-and-bolts about which is—who wants it. But you know, when you look at a native Hawaiian organization, you just have to keep true to what that word, what that phrase translates, native Hawaiian organization. It's got to be composed of native Hawaiians. I would feel very badly, and I am sure all my constituency would feel the same way, if you had all Haole or all Asian or whatever, all Indian board, in Hawaii being a native Hawaiian organization.

Mr. INOUYE. Well, that isn't what is being suggested.

Dr. ALULI. Well, that's the kind of assurances, Mr. Chairman, that, you know, when we read a bill like this on Molokai, we wonder about. Thank you.

Mr. INOUYE. Thank you very much.

Our next witness is Ms. Claire Hughes, Chairperson of the Committee on Health Concerns, Association of Hawaiian Civic Clubs.

STATEMENT OF CLAIRE HUGHES, CHAIRPERSON, COMMITTEE ON HEALTH CONCERNS, ASSOCIATION OF HAWAIIAN CIVIC CLUBS

Ms. HUGHES. Aloha. Aloha àuinala oukou. Good afternoon, Chairman Inouye and members of the Senate Select Committee on Indian Affairs. My name is Claire Kuuleilani Hughes. I am of Hawaiian ancestry. By profession I am a registered dietitian and a public health nutritionist. I speak today on behalf of the Association of Hawaiian Civic Clubs as a member of the Nutrition/Dental Task Force that put together the Alu Like report, as well as a member of the E Ola Mau group of Hawaiian health professionals.

I speak in support of S. 2243, which addresses the health status of native Hawaiians. We agree with section 1(3), which provides for any efforts to raise the health status for the native Hawaiian to the highest level possible. We also agree with the statement and we want to encourage maximum participation of the native Hawaiian in the planning and management of these health services.

Native Hawaiians can expect to die 6 to 10 years before any other ethnic group in our native land Hawaii. We suffer more, and more seriously, from all of the chronic diseases, as you have heard the statistics stated this morning. It is really very important for us to separate out the native Hawaiian from all others that live in Hawaii, to get the true picture of our health. We cannot use total populations. We do have people who live very long lives in Hawaii who are not Hawaiians.

We do have high age-sex mortality rates, lower life expectancy. We have a high rate of infant mortality, congenital abnormalities, and underweight infants, and we are at the greatest risk for diabetes, heart disease, and some forms of cancer. We have earlier ages for onset of diabetes, heart disease, and hypertension. We have significantly higher rates of heart disease and hypertension, and the highest rates of cancer. We have the poorest survival rates from cancer.

We rank highest in poor maternal health. We have a high rate of suicide among young adults and the elderly. We have the highest peridontal disease rates and poorest dental hygiene. We have a higher proportion of alcohol and narcotics use and higher rates of school performance impairment.

As a nutritionist, I would like to point out that nutrition is key in both the prevention of these chronic diseases as well as in the treatment of the diseases—heart disease, hypertension, diabetes, cancer, dental caries—as well as in the improved pregnancy outcomes. We can also assure best growth and development of children. The statistics also show our children are lagging in their growth.

A very strong nutrition health promotion component of education for all of the Hawaiians, native Hawaiians, to prevent disease and to ameliorate it in those who suffer the diseases and those who suffer from these conditions is needed. We have no data on the nutritional status of Hawaiians. We know nothing about the dietary practices which may be leading to these chronic diseases. We surmise that this is a big problem.

When we look at the U.S. studies done on the amount of fat intake in the diet, it would appear that the native Hawaiians now

eat three times the fat that their ancestors ate. And fat consumption or overconsumption is directly linked to cancer and heart disease. The ancient native Hawaiian diet was about 15 percent fat. Average Americans now eat a diet of 42 percent fat. Average Hawaii citizens take in 38 percent fat.

We have just about every nationally recognized fast-food shop in our towns now. Fortunately, not on Molokai, but they are on Oahu. French fries, a food that I didn't know as a child, is dominant. Children eat it every day by the bucketfuls. Fatty foods and sugared snacks start early and continue throughout life. Traditional native foods are very expensive and not always available. It is very expensive to be Hawaiian and to eat Hawaiian foods.

There have been significant changes to the overall food supply in Hawaii. We have lost our fishing rights in many areas. We don't have enough taro to supply poi for all of us.

In addition to this, I would like to say that training of native Hawaiian health professionals at all levels is a great need. There are just a few of us when you look at the numbers that sit on E Ola Mau compared to the magnitude of the problem. And we would like to see many more people trained in all levels of the health professions, not just the paramedical group, but for all of them.

I would like to thank you for the opportunity to speak this afternoon on behalf of the Hawaiian Civic Clubs, on behalf of E Ola Mau, the Hawaii health professionals group, as well as for the Alu Like task force on nutrition and dental health. Thank you.

[Prepared statement of Ms. Hughes appears in the appendix.]

Mr. INOUYE. Thank you. In all the groups serving Hawaiian health, how many are native Hawaiians?

Ms. HUGHES. I don't think we have any good numbers. We, E Ola Mau, tried to get information from each of the schools as to the numbers of graduates from the university and the school of social work and the school of public health. In all those schools they do not keep records of graduates by ethnicity.

I do know that I was the first registered dietitian to join the dietitians ranks back in 1959, and I was the first and am the only public health nutritionist that is of Hawaiian ancestry. And nutrition is a really key part, I think, in the healing of our illnesses.

The social work group has no statistics available to us. The school of nursing had nothing that they could give us when we asked for that. But we do have a number——

Mr. INOUYE. How many of your colleagues are of native Hawaiian ancestry?

Ms. HUGHES. Do you know?

Dr. ALULI. I am guesstimating 18. Naleen is saying maybe more, and I look to Dr. Terry Rogers, the dean of the medical school. And I am saying about 18 native Hawaiians in the State, and I think there are maybe as many U.S. mainland and elsewhere.

Mr. INOUYE. We have been told that there is a diet deficiency in protein, iron, phosphorus, and vitamins. Is that so?

Ms. HUGHES. When you look at the diet of the native Hawaiians that we did in our research for the Alu Like report, we did find that there were deficiencies in those nutrients. And certainly there is great change since earlier studies done before the 1940's and

1950's. The diet has changed significantly. It's very high in fat and sugar foods.

Mr. INOUYE. How would you rate the school lunch program in public schools in Hawaii?

Ms. HUGHES. I have had to review that for parents who were concerned about whether or not the nutritional value of the diet was adequate. And when you look at vitamins and minerals, there is an adequate amount of vitamins and minerals and the other major components in nutrition, but there is a little bit too much in the area of fat and salt. And those are two key nutrients leading to hypertension and heart disease.

The Department of Education has made an effort to reduce the amount of salt, ajinomoto, or monosodium glutamate, is outlawed in its use in school cafeterias now. But salt is still a component of many of the prefabricated meats that are used.

Mr. INOUYE. Just for the record, since most of my colleagues are not aware of what a "poi" is, could you tell them?

Ms. HUGHES. "Poi" is a staple of the native diet. You make poi by mashing the cooked corn of the taro plant, very much like you make mashed potatoes, only the consistency is a little stickier. And it's as tasty as mashed potatoes would be without salt and without milk and the butter that you add to mashed potatoes.

Hawaiians keep the poi for a day or two and allow it to ferment slightly for a little more acid flavor. We have various kinds of poi, some very sweet and reddish in color, others gray. For all of the poi we have, however, newcomers really don't like the taste nor are they used to the consistency.

But it is a staple of the Hawaiian diet, and the Department of Economics and Planning for the State of Hawaii estimates that the native man in the traditional Hawaiian group would have eaten about 15 pounds of poi every day, and that would have provided him with about 3,000 calories or about half the calories he would need for the day to do his hard labor. So we have gone from a very high complex carbohydrate diet to a high-meat diet now.

Mr. INOUYE. Thank you very much.

Our final witness on the panel is Dr. Naleen Andrade, Division of Psychiatry at Queens Hospital in Honolulu.

STATEMENT OF NALEEN ANDRADE, CHIEF PSYCHIATRY RESIDENT, UNIVERSITY OF HAWAII SCHOOL OF MEDICINE

Dr. ANDRADE. Senator Inouye, before I begin my formal testimony, just as a response to your question about how many native Hawaiian professionals there are. In the medical school as far as medical students of native Hawaiian ancestry, there is anywhere from 5 to 7 percent of the school's population that are part-Hawaiian or are of native Hawaiian ancestry. I think also that our medical school has done probably the most in the Nation in increasing the numbers of native Hawaiian physicians in Hawaii.

Aloha auwinala ia oukou apau. Good afternoon to all of you.

Mr. INOUYE. Aloha.

Dr. ANDRADE. My name is Naleen Andrade. I am a native Hawaiian born, raised, and educated in the Hawaiian Islands. I am also a

physician and presently the chief psychiatry resident at the University of Hawaii School of Medicine.

Today I speak as a member of the Hawaiian House Research Consortium and a member of E Ola Mau, which means "to perpetuate life." It is a name that we took also from the Hawaiian health needs study in the formation of a new professional group of health professionals composed of native Hawaiians.

The Hawaiian Health Research Consortium study represents a dynamic study and a dynamic body of knowledge on native Hawaiian mental and total health care needs

Mr. INOUYE. Why don't we take a short recess. That buzzer means I have to rush down and vote. I will be right back. The committee will stand in recess.

[Recess taken.]

Mr. INOUYE. The hearing will please come to order. We will now continue with Dr. Naleen Andrade.

Dr. ANDRADE. Senator Inouye, for the record I would like to provide the actual statistics on the native Hawaiian health professionals, particularly amongst native Hawaiian physicians that I talked with you earlier about. Statistics are about 7 percent of the med school population graduating are native Hawaiians.

The Hawaiian Health Research Consortium study represents a dynamic body of knowledge on native Hawaiian health care needs. Some of the major highlights of the Mental Health Task Force report are as follows, and I will summarize without being too redundant, since many of these findings have already been put forth.

There are higher proportions of social problems with families—in comparison with State population—21 percent—which is the highest; a higher proportion of social problems with children—25 percent—from a Department of Health study. A higher proportion of assaultive acts amongst native Hawaiians, and a higher proportion of antisocial behavior.

Second, there's a higher proportion of alcohol and drug abuse. They rank second and first in the State of Hawaii in comparison to other ethnic groups. There is a higher proportion of school performance impairment. Also, a higher rate of suicide, with a rate of increase of 130 percent since 1962. There are higher rates of child abuse, with a rate of 354 cases per 100,000; and this ranks second only to Samoans in comparison to other——

Mr. INOUYE. May I interrupt?

Dr. ANDRADE. Yes.

Mr. INOUYE. The suicides, are they for the elderly or for all age ranks?

Dr. ANDRADE. This concerns particularly young adult males and elderly males as well.

Mr. INOUYE. Please continue.

Dr. ANDRADE. There is a higher rate of residents in correctional institutions. There are higher rates of academic failure and poor school performance, which the Kamehameha Schools Bishop Estate excellent native Hawaiian educational project report shows very eloquently.

There are higher levels of stress, as indexed by leading stress marker such as poverty, educational level, single-parent households, and dwelling densities.

Finally, the Mental Health Task Force study showed that the native Hawaiians underutilize mental health services because they fail to accommodate native Hawaiians values and life styles in their structure and delivery.

As a native Hawaiian psychiatrist with an interest in cultural psychiatry, I have been working on developing psychotherapeutic approaches in which Western and Hawaiian psychiatric concepts are integrated. At this time I would like to present a case that demonstrates, first, the findings that I discussed earlier, and second, an alternative and perhaps more effective treatment plan.

I was asked to do a cultural consult on a 34-year-old native Hawaiian man who was thought to be psychotic by his haole—that's the generic equivalent of "the white man"—therapist because he spoke of ancestral spirits and religious medicinal rituals.

My evaluation showed that he was not psychotic and that he perceived himself as an average Hawaiian. He was unemployed, suffering from chronic depression and a lower back injury. He came from a broken home where he had been abused as a child. He was divorced and, himself, a spouse abuser. He also abused alcohol and valium and had a history of both suicidal and homicidal behavior.

His core conflict, in my analysis, was that he had a profound separation of his sense of self or identity, in that he identified his haole or Western part that he viewed as cold, intellectualizing, and manipulative—something bad to get rid of—and he viewed his Hawaiian self or part of his identity as sensitive, intuitive, harmonizing, but easily intimidated.

The focus of treatment was helping this man to integrate his Hawaiian and haole selves into a unified whole so that he could appreciate both weaknesses and strengths and take responsibility for the changes in his life.

This was done by using Hawaiian religious beliefs as represented in the Kumulipo, our creation myth, that differentiates and expounds an integration of dualistic, often opposing, qualities in humankind and the universe that we live in. I used the Kumulipo and in my therapy with this man cognitively reframed his perceptions. With this new cognitive construct, his therapists were then able to treat his many other problems.

Today this man is free from depression. He no longer abuses drugs or women. He has a job and a stable relationship and is attending college part-time. Thus, it was by implementing the native Hawaiian health concept of integrating the biological, the psychological and the spiritual along with the Western cognitive therapeutic approach of psychotherapy that this man was successfully treated.

The Hawaiian health bill, S. 2243, represents a priceless opportunity to expand upon just this kind of treatment, and it offers an invaluable, sometimes curative, alternative to suffering. Today, individually and as a unified group, all of us of the Hawaiian Health Research Consortium in our own stylized way have attempted to demonstrate the breadth as well as the depth of the current native Hawaiian health situation and how it may be improved.

Our Hawaiian people are suffering and in great need of relief and research. As native Hawaiians and as fellow Americans, we

need your support as we too strive to claim our right to life, liberty, and the pursuit of happiness. Thank you very much.

[Prepared statement of Dr. Andrade appears in the appendix.]

Mr. INOUYE. Thank you very much. You refer to native Hawaiian medical practices. Are there any practicing Kahuna physicians today?

Dr. ANDRADE. We have a wide variety. One of the things that the E Ola Mau, the native Hawaiian health professional group that I referred to earlier, is attempting to do with the help of Alu Like and OHA as well is to make a statewide conference to bring together people who are Kahuna Lapaau.

Mr. INOUYE. Would you explain what that is?

Dr. ANDRADE. A Kahuna Lapaau is a specialist who is well versed in herbal medicines as well as Hawaiian medicinal practices, and a Kahuna Lapaau also by virtue of prayers, chants, the uses of herbs, and massage—or lomi lomi is the Hawaiian term for it—brings about the integration that I referred to of the biological, the psychological, and the spiritual to help create treatment cures or to alleviate suffering as much as possible.

Mr. INOUYE. There are practitioners, though?

Dr. ANDRADE. Yes; there are.

Mr. INOUYE. Do you have any numbers?

Dr. ANDRADE. There are no numbers. And the problem is because if you take the historical cultural perspective, when Hawaii was being Americanized, it was not a good thing to be a native Hawaiian, and because of this, so many of our rituals went underground. Today we are enjoying the rebirth of things Hawaiian, and with that a lot of the Kahuna are coming to light, sharing their knowledge.

What we hope is that we can standardize and assure quality care by having these Kahuna come out and share that they are specialists and share openly.

Mr. INOUYE. Thank you very much.

Ms. Rubin, did you have a closing statement?

Ms. RUBIN. Senator Inouye, we appreciate the opportunity of providing this information to you. We as a panel and as the consortium and as those people who are represented in our constituencies would urge the passage of Senate measure 2243, and we appreciate your introduction of it.

Mr. INOUYE. Without objection, all of your statements will be made part of the record in total, and the consortium reports will be made part of the record.

Ms. RUBIN. Thank you.

Mr. INOUYE. I thank the panel very much.

Our next witness is the dean of the University of Hawaii School of Medicine, Dr. Terence Rogers.

Welcome, Dr. Rogers.

STATEMENT OF TERENCE ROGERS, M.D., DEAN, UNIVERSITY OF HAWAII SCHOOL OF MEDICINE, HONOLULU, HI

Dr. ROGERS. Thank you, Mr. Chairman.

Mr. INOUYE. Please use the microphone.

Dr. ROGERS. Mr. Chairman, and the other members of the Senate Select Committee on Indian Affairs, I am Terence Rogers, dean of John A. Burns School of Medicine at the University of Hawaii. I am very grateful for the opportunity to testify in favor of S. 2243 both in general and with respect especially to section 4 regarding community health centers and section 5 regarding the health service scholarship program.

It is appropriate to mention that, with the support of yourself, we have been able to maintain an aggressive affirmative action program to educate young native Hawaiians of both sexes as physicians. To date we have graduated about 60 native Hawaiian medical doctors. And part of the confusion that arose earlier is that many of these are still in postgraduate training and not returned to Hawaii. And we have a further 25 in the pipeline.

This is not an add-on minority program, but was an integral part of the original planning for the school's mission. The scholarship program proposed in the bill would be a great asset in this context because our affirmative-action policy of admitting Hawaiian students does not necessarily assist them to pay the costs of living.

I would also mention that all postgraduate medical training in Hawaii—that is, all residencies—are carried out under the aegis of the medical school. And these residents and fellows would be part of the, I say, infantry—and off the record, I do not mean that as a patronizing reference to the infantry—in delivering the actual medical care involved in a Hawaiian community health center.

Again, a proportion of the residents are themselves Hawaiian and epitomized by Dr. Andrade, who testified today. She mentioned that she is chief resident in psychiatry. She will become assistant professor of psychiatry on July 1. She came to her M.D. all the way through our minority opportunities program and has been one of the most satisfactory students, residents, and human beings it has been our good fortune to recruit.

Dr. Aluli was one of our earlier graduates, and he and I had some disagreements which have led to a lasting mutual trust and respect.

Our department of internal medicine, with the greatest cooperation of the Queens Medical Center, has in fact taken over the care at the Queen Emma Clinic, the major inner-city clinic, with a large Hawaiian clientele. This process could be extended and contain a uniquely Hawaiian subprogram with the kind of support this bill would provide.

The thrust of my foregoing remarks is that we are already involved in the actual delivery of care to the economically stressed Hawaiian community and have real skills and organization to offer.

We have enough Hawaiian—native Hawaiian—talent in the University of Hawaii as a whole to set up, for example, a treatment and support center directed at alcoholism in which the Hawaiian clients would encounter only Hawaiian health professionals.

Mr. Myron Thompson, a trustee of the Bishop Estate, and I have had extensive discussions about the ominous epidemiological picture among Hawaiians alluded to in the bill and referred to by the Hawaiian organization panel. The rapport I enjoy with Mr. Thompson is such that we in the medical school would be very comforta-

ble with his serving, for example, as an interface with the Hawaiian organizations, since as it has been made clear, we are not a Hawaiian organization.

We regard it as an integral part of our mission, and the vision of the late Governor Burns, to participate in the programs this bill will make possible. It would be difficult to do this, however, if the medical school faculty and house staff were simply the hired help in a health program. It would be necessary for the medical school to have a major role in policy development and implementation.

Although I have not had an opportunity to discuss it specifically with him, I know I can speak for Dean Jerrold Michael of our University School of Public Health in their having a shared interest in the bill, especially regarding health promotion and disease prevention.

I thank you, Senator.

[Prepared statement of Dr. Rogers appears in the appendix.]

Mr. INOUYE. I thank you very much. I appreciate the mission of your medical school in providing the special scholarship program for native Hawaiians. Would you say that all of your graduates today are doing well?

Dr. ROGERS. Yes, sir; I am a disciplinarian, and unless they do well, they don't graduate.

Mr. INOUYE. Are most of them in private practice, or are they in Government service?

Dr. ROGERS. Mostly in private practice, a handful in the military and some in other kinds of Government service.

Mr. INOUYE. So you believe that, with this bill and the scholarship aspect of it, you could add more native Hawaiians to your program?

Dr. ROGERS. Yes.

Mr. INOUYE. I thank you very much for your support and for your testimony.

Dr. ROGERS. Thank you, sir.

Mr. INOUYE. Our next witness is the administrator of the Office of Hawaiian Affairs, Mr. Kamaki Kanahele III.

Welcome, Mr. Kanahele.

STATEMENT OF KAMAKI KANAHELE, ADMINISTRATOR, OFFICE OF HAWAIIAN AFFAIRS, HONOLULU, HI

Mr. KANAHELE. Senator, although in my written testimony I read it as good morning, we are physically here from Hawaii in body and in mind it's 8:30 in the morning at home, sir, and so this person can still feel that jet lag. So, Aloha kahakia to you. Good morning.

My name is Kamaki Kanahele, and I am the administrator of the Office of Hawaiian Affairs. I would like to thank Senator Mark Andrews, chairman of this committee, for scheduling this most important hearing. The Office of Hawaiian Affairs strongly supports adoption of S. 2243.

Before I continue, Senator, I would like to request that I summarize and that my entire testimony be submitted for the record in full.

Mr. INOUYE. Without objection, so ordered.

Mr. KANAHELE. Mahalo. Thank you very much.

I would like to share with you a little background on the Office of Hawaiian Affairs as a means of providing the members of this committee with some understanding of the role and interests of OHA, or Office of Hawaiian Affairs, in this matter.

According to legislation creating the Office of Hawaiian Affairs, it is the principal public agency in Hawaii responsible for the performance, development, and coordination of programs and activities relating to native Hawaiians. It is governed by a nine-member native Hawaiian board of trustees elected by approximately 44,000 native Hawaiians. As a result, the OHA trustees are directly accountable to their beneficiaries, the native Hawaiian people.

OHA was created in 1978 by an amendment to the State constitution. The basis for its establishment, however, dates back to our State Admissions Act of 1959. The act created a public land trust, the proceeds of which were to be used for five purposes. One of the purposes was the betterment of conditions of native Hawaiians.

In 1979 the State legislature passed Act 196, which established the basic structure of OHA. This act was subsequently codified as chapter X, Hawaii Revised Statutes. For your convenience a copy of chapter X is attached as appendix A. It mandates OHA to serve as a receptacle for reparations and to act as a clearinghouse for Federal and State assistance involving Hawaiian programs and projects.

OHA is also responsible for advising, informing, and coordinating Federal, State, and county activites relating to native Hawaiians. It is with this role in mind that OHA submits this testimony.

In meeting the native Hawaiians health needs, because of the dire health statistics enumerated today. S. 2243 is particularly important to the native Hawaiian community. The services and programs proposed in the bill—health promotion and disease prevention, community health centers, health service scholarships, and health needs assessments, health education and health services referrals—can go a long way in improving the health conditions of native Hawaiians.

The manner in which these services and programs are planned and delivered, however, is extremely crucial. It is important to overcome cultural barriers that may have previously prevented native Hawaiians from receiving health services that could ahve prevented or treated medical problems.

To help overcome these barriers, native Hawaiians should participate in the creation and control of health care services that will be provided in their communities and native Hawaiian traditions and culture should be incorporated into any proposed programs or services. For example, education/prevention programs can be offered in conjunction with existing native Hawaiian organizations which will increase the success of the program by implicitly providing the approval and support of the social environment of the individuals.

Family support can be crucial in health care also. Therefore, working with the families as well as native Hawaiian community organizations may be an important aspect of providing health care.

The training of native Hawaiians to become health care providers is also important to ensure the native Hawaiian patients' ac-

ceptance of the health care provider. The provision of health service scholarships to native Hawaiians would increase the number of native Hawaiians in the health care field, in which they are so sorely underrepresented, and assure that the health care provider is sensitive to the native Hawaiian and his culture.

It is a most important agenda that the cultural parts of this area be considered, Senator. Statistically, to reiterate the importance of the survival of the Hawaiian race, there are approximately 28 million blacks, 15 to 16 million Hispanics. The total culmination of the native Americans population in this country, as measured statistically, is about $3 million, with a total Hawaiian and native Hawaiian population in Hawaii today at approximately 180,000, with native Hawaiians being approximately 40,000. Of that total 180,000, 58.2 percent are under the age of 19.

The race is a dying one, Senator, and our care and our need in behalf of this bill is required.

The issue is no longer the health of the people, but the survival of the race. The Hawaiian people, in their beautiful islands, have somehow in their time, for many, have been considered a detriment to the future of many things to come. The Hawaiian needs to survive—and will. In time, our race collapsed with the influence of foreign diseases—40,000 left, according to Congressman Akaka in the late 1800's--today the race has improved slightly. Healthwise, it has been destructive to not only the people, but the lifespan in which we can live to call ourselves Hawaiians living in Hawaii.

In summary, I would like to reiterate OHA's support for the adoption of S. 2243. There are many serious health problems in the native Hawaiian community, and S. 2243 would make it possible for native Hawaiians to address these problems by planning for and controlling health care services to meet their health needs.

It is most important that I express that the native Hawaiian needs to be a part of this, effort 100 percent, to know how, when, and where they can be accommodating to save their race. The Office of Hawaiian Affairs would like to express its appreciation to this committee, and especially to you, Senator. And may I say Aloha with great Mahalo to your distinguished staff for bringing this most important bill into place today. Thank you so very much.

[Prepared statement of Mr. Kanahele appears in the appendix.]

Mr. INOUYE. Thank you very much, Mr. Kanahele.

Section 2, paragraph 4 of the bill, says the following:

> The term "native Hawaiian organization" means any organization that serves and represents the interests of native Hawaiians and is recognized by the Governor of the State of Hawaii for the purpose of planning, conducting, or administering programs authorized under this act.

Dr. Aluli has suggested that the change may be justified, that it should be a matter that is determined by Hawaiians for Hawaiians. Would your organization, OHA, be prepared to serve in this category to recognize and provide accreditation for "a native Hawaiian organization?"

Mr. KANAHELE. By law we are constitutionally mandated to do so, Senator.

Mr. INOUYE. And you have the capacity to do that?

Mr. KANAHELE. We can.

Mr. INOUYE. I thank you very much.

Mr. KANAHELE. Mahalo.

Mr. INOUYE. Would that satisfy you, Dr. Aluli?

Dr. ALULI. Partially; but my concern is also the facilitation of the programs to benefit the native Hawaiian. Alu Like has done so much to legitimately follow through with many programs. The Office of Hawaiians Affairs is just beginning, and is struggling. But I would like to talk to you more in depth about this sensitive Hawaiian matter.

Mr. INOUYE. Before we get to our final panel, it is my honor to present our distinguished Senator from the State of Hawaii, Senator Spark Matsunaga. Senator Matsunaga has been extremely busy these past many hours. I think he worked until 3 a.m. on the tax bill.

Welcome to the committee, and congratulations on the tax bill, Senator.

STATEMENT OF HON. SPARK MATSUNAGA, U.S. SENATOR FROM HAWAII

Mr. MATSUNAGA. Thank you very much, Mr. Chairman. Mr. Chairman, I am delighted to join with other members of the Hawaiian congressional delegation and the distinguished representatives of the native Hawaiian community, in supporting S. 2243, a bill which would help improve the health status of native Hawaiians.

You may recall, Mr. Chairman, that you and I proposed such a study to be conducted by the Secretary of Health and Human Services, with the assistance of the State of Hawaii, to determine the special health care needs of native Hawaiians. In fact, this committee considered and approved our bill during the 98th Congress, adding it as an amendment to the Indian Health Care Act. Regretfully, that bill was vetoed by President Reagan and was not enacted into law.

I commend you and the members of this select committee for your continued effort about the health care needs of native Hawaiians and for holding these hearings and taking action to improve the health care status of native Hawaiians.

Evidence collected over the past several years by the Hawaii State Department of Health reveals beyond a shadow of a doubt that native Hawaiians are, in fact, a medically underserved population greatly in need of the special Federal assistance which S. 2243 would provide. They suffer a high incidence of heart disease, cancer, hypertension, and diabetes than any other segment of Hawaii's population and have an infant mortality rate that has remained high in the face of declining rates in other segments of the population.

The great tragedy is that most of these conditions are preventable through changes in life style and diet and with better, more timely medical care. S. 2243, in recognition of the situation, would establish a health promotion and disease prevention program for native Hawaiians and would provide for health planning grants and research on the health needs of native Hawaiians.

In addition, S. 2243 would enable native Hawaiians to help themselves through the use of Hawaiian professionals who would teach

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the basics of nutrition, physical fitness, and stress management to members of the community as well as through the use of native Hawaiian organizations to refer individuals for health care and treatment and through a scholarship program for native Hawaiians who are interested in careers as health care professionals.

This, I believe, is one of the bill's most attractive features, and I am sure will help raise the consciousness of native Hawaiians with respect to the importance of preventive health care.

Mr. Chairman, I fully support S. 2243, and urge that the committee take favorable action upon it.

Again, I thank you for holding these hearings promptly on the bill, and personally I fully appreciate the great effort that you, Senator Inouye, as the senior Senator from Hawaii, have been exerting in the direction of making life for the native Hawaiians better than it is today.

Mr. INOUYE. Senator, it would add much to the success of this bill, and it would be a great honor, if you would serve as a cosponsor of it.

Mr. MATSUNAGA. I was hoping you would ask me, Senator. You had only needed to ask, and I ask that I be included as a cosponsor of the measure.

Mr. INOUYE. Without objection, Senator Spark Matsunaga will be listed as a cosponsor of S. 2243.

I thank you very much, Senator.

Mr. MATSUNAGA. Thank you very much. I appreciate it.

Mr. INOUYE. Our final panel, panel 7, is made up of two members, very distinguished members of the nursing community of the State of Hawaii. The first member is Dr. Genevieve Lehuananiokilauea Kinney of the Hawaiian Nurses Association. Bernadette Pang is a member of the faculty of the University of Hawaii School of Nursing.

Dr. Kinney, would you like to open with your statement?

STATEMENT OF GENEVIEVE LEHUANANIOKILAUEA KINNEY, R.N., PH.D., HAWAII NURSES ASSOCIATION, HONOLULU, HI, ACCOMPANIED BY BERNADETTE PANG, R.N., M.N., FACULTY MEMBER, UNIVERSITY OF HAWAII SCHOOL OF NURSING, HONOLULU, HI

Ms. KINNEY. Mr. Chairman, committee members, Aloha. I submit my written statements for the record and will summarize my statement for brevity.

Mr. INOUYE. Without objection, your full statement will be made part of the record.

Ms. KINNEY. I am Genevieve Lehuananiokilauea Kinney, a registered nurse with a Ph.D. in transcultural nursing. I am director of nursing programs at the University of Hawaii at Hilo and am representing the Hawaii Nurses Association [HNA], of which I am a member, which is a constituent of the American Nurses Association [ANA], where I serve on the cabinet on professional nursing education.

We would like to commend the committee for recognizing the critical needs that S. 2243 addresses. The E Ola Mau native Hawaiian health needs study shows what nurse researchers have docu-

mented: that monocultural approaches to health care are ineffective in meeting health and nursing needs of diverse cultural groups of patients.

It is distressing that although health care systems exist for the State of Hawaii, they are underutilized by the native population. Many of the devastating health problems could be eradicated or drastically reduced by enactment of this legislation.

We also applaud Senator Inouye for his commitment to nursing and his recognition of the importance and contribution of nursing research. Funding for nursing research, which began at $1 million, now stands at $14.5 million. ANA's Council on Cultural Diversity and Nursing Practices has assisted in targeting these research dollars to focus on the relationship of cultural diversity to health care beliefs and practices.

At the time of the E Ola Mau study, nursing care delivery to the Hawaiian population was not addressed. This was unfortunate because nurses have provided care to the Hawaiians for the last 100 years and are often the transcultural link between the underutilized services and the Hawaiian in need. Such information is important because nursing intervention has been demonstrated to prevent long-term or catastrophic illnesses.

HNA has conducted two transcultural nursing conferences during the last 3 years to address the gap between non-Hawaiian providers and Hawaiians.

Problems have arisen in a number of areas—that is, Molokai—have lost obstetrics and gynecological services because of the malpractice crisis. At the present time, one nurse midwife, with a supervising physician, is providing those services. Similarly, public health nurses, who provide community services, are stretched to the maximum. Two public health nurses have a caseload of 400 patients each. They provide immunizations, well-baby care, and limited home health care for the elderly.

There is a large group of Hawaiians between the ages of 5 to 60 years who lack skilled nursing care. One community health clinic is expected to close because of economic losses. Necessary followup care is not occurring, because a patient may only have one initial contact with the health care system. Chronic understaffing at acute care facilities exist on other islands, which compounds the problem.

Sections 3(a), 2(6), and 5(a) of S. 2243 will help to remedy problems by utilizing nurses from culturally diverse groups to provide less costly and more effective care for the native Hawaiians and will integrate their unique cultural and allopathic systems of care into the delivery system.

As the first native Hawaiian to benefit from the minority fellowship program of ANA, I know that native Hawaiian nurses are in a unique position to assist both patient and health care providers as the understanding health care system of the majority culture, in addition to the culturally diverse health care system.

Section 4(a)(1), authorizing community health care centers developed by native Hawaiian organizations, is necessary to effect outreach of those not currently in the delivery system. Access to care can be improved by providing relevant and compatible choices in health care delivery systems. Knowledge of cultural diversity and a

background in community and home health care enables nurses to most effectively provide health care alternatives to clients.

Cultural differences cannot be addressed without attention to the racial prejudice or discrimination that can be found in the delivery system of health care to cultural minorities. Responsive nursing care requires the integration of cultural minority nurses into the health care delivery system through increased education and training.

ANA has contributed to the development of ethnic minority nurses and nursing by administering two federally funded projects that assist these nurses in earning doctoral degrees with either a clinical or research focus in the social and behavior sciences. Since 1974, participants in the ethnic/racial minority fellowship program have gained experience by working in congressional offices. Fellowships have been awarded to 122 nurses, 70 of whom have earned doctorates. These nurses can now assume leadership roles in nursing practice, education, and research, and to make significant contributions to meeting the needs of groups disenfranchised by the health care system.

Mr. Chairman, ANA offers our support for S. 2243 which is a solid commitment to improving the health status of native Hawaiians so that they can have full participation and accessibility to affordable cultural health care systems which promote: their cultural identity and pride; their spiritual connection and affection for their ancestors and the aina in these United States, Mahalo Nui Loa Kakou—thank you to all of us—Malama Pono Kakou—let us all take care.

[Prepared statement of Ms. Kinney appears in the appendix.]

Mr. INOUYE. Thank you very much, Dr. Kinney.

Our final witness is Ms. Bernadette Pang, member of the faculty of the University of Hawaii School of Nursing.

Ms. Pang.

STATEMENT OF BERNADETTE PANG, R.N.

Ms. PANG. Mr. Chairman, Senator Inouye, and members of the select committee, I would like to thank you for the opportunity to appear before you. My name is Bernadette Pang, and I am representing the University of Hawaii School of Nursing. I am a professional registered nurse and educator who has been involved in nursing for over 17 years. More importantly, I am of native Hawaiian ancestry. In light of the staggering health needs of native Hawaiians, I am sad to report that there are only a few nurses who are of native Hawaiian ancestry. As an ethnic group, Hawaiians are underrepresented in all of the health professions.

I come before the members of this committee to ask for your support for S. 2243.

In 1984, Margaret Heckler, then the Secretary of Health and Human Services, reported that Americans are living longer and infant mortality had declined. However, this has not been the case for minorities. Secretary Heckler's Task Force on Black and Minority Health exposed the disparity and the burden of death and illness among minorities as compared to our Nation's population as a whole.

The native Hawaiian Health Needs Study gives further support to this disparity. The current health system has failed to address and improve the health status of native Hawaiians. It has become apparent that the health plight of the Hawaiian people is the result of historic and cultural factors.

There are several reasons why we support S. 2243. First, the bill addresses the need for the development of a health delivery system that will be accessible and acceptable. It incorporates the life style and values of the Hawaiian people so that culturally acceptable methods are developed to promote health and reduce disease.

Second, this bill requires the involvement of native Hawaiian communities and organizations possessing unique insights into their own health problems. These organizations and coalitions are important in practical resources because they have grass-roots support, enabling them to have a finger on the pulse of the health needs of the Hawaiian people.

Given this input, these organizations are able to increase the motivation and participation of the Hawaiian people to improve their health status.

Third, this bill provides for a health screening component, to increase native Hawaiian representation in all levels of health care. There should be particular emphasis on increased participation in the nursing profession, based on the traditional roles that nurses have performed as health care providers and in the prevention of health problems.

More than any other health professional, nurses have established the unique record for providing service to underserved populations. In order to further this service to native Hawaiians, the nursing profession is in need of increased Federal Government support. The development of native Hawaiian health professionals who are culturally sensitive provides for role models and is essential for improving health care. In addition, this bill makes provision for cultural awareness training for non-native Hawaiian health care providers.

Mr. Chairman, we are engaged in an urgent battle against poor health and the death of a people in their native land. Members of this select committee and Congress can claim victory in improving the quality of life and health of the native Hawaiians by supporting S. 2243. Failure to support this bill would mean a retreat from a responsible health care policy that will haunt us with spiraling health care costs and the tragic loss of a gentle people. This bill represents the turning point for our Government in meeting its responsibilities and obligations.

As a nurse of Hawaiian ancestry, I strongly believe I cannot ask others to help native Hawaiians if I do not do everything in my power to help them. But I know that my efforts alone cannot conquer the health problem. Combatting the effects of illness and disease can only be achieved with both the heart and a helping hand.

Mr. Chairman, the health status of native Hawaiians is dependent upon your leadership and the support of members of this select committee. I thank you and the members of this committee for their support shown in the past, and hope for your continued support in the future.

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I would like to commend you, Senator, for your work and the committee's work on this fine piece of legislation.

[Prepared statement of Ms. Pang appears in the appendix.]

Mr. INOUYE. I thank you very much, Ms. Pang. It is regrettable that the native Hawaiian nurses were not called upon to participate in this study project. I hope that in phase II of this process, the nurses will not be kept out. As you are well aware, I have always looked upon nurses as professionals, and there are many bills that have become laws to carry out that professional thought of mine.

I would hope that the representatives of native Hawaiian organizations present here today will look upon nurses for expert support. Certainly, they will have much to offer you.

I thank you very much.

Ms. PANG. Mahalo. [Thank you.]

Mr. INOUYE. Since the bill is presently scheduled to be marked up next week, may I request that if you do have additional statements to submit, that these statements be submitted by 5 p.m., Friday, May 9.

The hearing is adjourned.

[Whereupon, at 4:16 p.m., the committee was adjourned.]

APPENDIX

Additional Material Submitted for the Record

STATEMENT OF SENATOR MARK ANDREWS

GOOD AFTERNOON. TODAY THE SELECT COMMITTEE WILL RECEIVE TESTIMONY ON TWO BILLS THAT HAVE BEEN REFERRED TO THE COMMITTEE: S. 2260, A BILL TO PROVIDE FOR THE SETTLEMENT OF CERTAIN CLAIMS ARISING OUT OF ACTIVITIES ON THE PINE RIDGE INDIAN RESERVATION; AND S. 2243, A BILL TO IMPROVE THE HEALTH STATUS OF NATIVE AMERICANS.

WE WILL FIRST RECEIVE TESTIMONY ON S. 2260 WHICH WAS INTRODUCED BY SENATOR ABDNOR ON MARCH 27, 1986. THE NEED FOR THIS BILL ARISES OUT OF EVENTS SURROUNDING THE 1973 OCCUPATION OF WOUNDED KNEE, SOUTH DAKOTA BY MEMBERS OF THE AMERICAN INDIAN MOVEMENT, AND THE FEDERAL GOVERNMENT'S ROLE IN RESPONDING TO THE OCCUPATION DURING THE PERIOD BETWEEN FEBRUARY 27, 1973 AND MAY 8, 1973. IN THE COURSE OF THIS OCCUPATION A LARGE NUMBER OF PEOPLE SUSTAINED DAMAGES TO OR LOSS OF PROPERTY AND PERSONAL INJURIES. IT IS THE INTENT OF THIS BILL TO PROVIDE COMPENSATION TO INNOCENT PERSONS WHO SUSTAINED DAMAGES DURING THIS PERIOD.

BEFORE WE HEAR FROM THE DEPARTMENT OF THE INTERIOR, MY COLLEAGUE AND SPONSOR OF THIS BILL, SENATOR ABDNOR, HAS A STATEMENT.

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PREPARED STATEMENT OF RONALD ESQUERRA, DEPUTY TO THE ASSISTANT SECRETARY FOR INDIAN AFFAIRS (OPERATIONS), DEPARTMENT OF THE INTERIOR

Good afternoon Mr. Chairman and members of the Committee. I am pleased to be here with you today to discuss S. 2260, a bill "To Settle Certain Claims Arising Out Of Activities On The Pine Ridge Indian Reservation."

S. 2260 is essentially a private relief bill to compensate 113 individuals and businesses (who were plaintiffs in a prior legal action) for amounts ranging from $731 to $490,934 each for personal injuries or damages to their property during the occupation of Wounded Knee, South Dakota, which occurred between February 27, 1973 and May 8, 1973. The bill also provides $26,486.44 to the Dakota Plains Legal Services, formerly South Dakota Legal Services Corporation for services provided.

We oppose enactment of S. 2260.

The plaintiffs have disavowed any claim based on a legal right of recovery and instead attempted to build a case in support of a claim for purely equitable relief. The time periods involved in their claims began with the incidents leading up to and including the November 4, 1972, takeover of the BIA building in Washington, D.C., and continued through the occupation of Wounded Knee, South Dakota, which began on February 27, 1973 and ended on May 8, 1973. The plaintiffs contended that the United States actions, or failures to act, were responsible for the damages and losses suffered by them as a result of the Wounded Knee occupation.

The United States Court of Claims completed a thorough investigation and analysis of the claims made by the petitioners. The report entitled "The Innocent Victims of the Occupation of Wounded Knee, South Dakota v. The

United States (Cong. Ref. 4-76), Findings of Fact and Recommended Conclusions to Accompany the Opinion of the Trial Commission filed June 10, 1981", concludes:

> "The above ultimate conclusions remove the predicates necessary for plaintiffs to have any basis for equitable claims against the United States. While it is true that plaintiffs did incur property damages and losses as a result of the occupation of Wounded Knee by militant forces of AIM, the United States should not be deemed legally and/or equitably liable for said damages since its reaction and response to the occupation was prompt, reasonable and honorable. Expert testimony indicated that the government's conduct in terminating the Wounded Knee occupation comported most favorably with present-day accepted and recognized standards, policies, practices and procedures utilized in handling hostage and barricade situations. Under such circumstances, any monetary award to plaintiffs for damages arising out of the Wounded Knee occupation would be a gratuity."

Although the Court of Claims determined that the monetary damages these people suffered amounted to about $1,600,000, the findings I have quoted indicate that it is not appropriate for the Federal Government to compensate them.

This concludes my prepared statement. I will be happy to answer any questions you may have.

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PREPARED STATEMENT OF SENATOR DANIEL K. INOUYE

I WISH TO THANK THE CHAIRMAN FOR THIS OPPORTUNITY TO DISCUSS A MATTER OF URGENT AND AND GROWING CONCERN TO THE NATIVE HAWAIIAN POPULATION.

S.2243 IS A BILL TO IMPROVE THE HEALTH STATUS OF NATIVE HAWAIIANS. THE URGENCY OF THE BILL IS MADE EVIDENT BY THE FINDINGS OF A RECENTLY COMPLETED FIVE-PART STUDY ON THE HEALTH CARE PROBLEMS OF NATIVE HAWAIIANS. THIS REPORT ON THE HEALTH OF NATIVE HAWAIIANS WAS LONG OVERDUE.

THE NEED FOR MORE HAWAIIANS IN THE HEALTH FIELD WAS DEMONSTRATED IN THE COURSE OF THIS STUDY BY THE DIFFICULTY ENCOUNTERED IN LOCATING HEALTH CARE PROFESSIONALS OF NATIVE HAWAIIAN ANCESTRY, WHO WERE PARTICULARLY SOUGHT FOR THEIR PERSPECTIVE ON THE STUDY. DESPITE A LIMITED SIX-MONTH TIME FRAME, THIS CONSORTIUM PRODUCED A REPORT WHICH DR. SHERIDAN WEINSTEIN, OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR REGION IX, HAS PRAISED AS A MODEL FOR OTHER GROUPS TO EMULATE.

THE STUDY, KNOWN BY ITS HAWAIIAN NAME, "E OLA MAU"--WHICH MEANS "PERPETUATING LIFE"---DEPICTS THE DISTURBING HEALTH AND SOCIAL PROBLEMS FACING NATIVE HAWAIIANS, A PEOPLE ONCE EXCEPTIONAL FOR THEIR PHYSICAL PROWESS, AND POSSESSING THE MOST HIGHLY DEVELOPED CULTURE AND SOCIAL ORGANIZATION IN THE PACIFIC. TODAY THE NATIVE HAWAIIANS HAVE BEEN RELEGATED TO THE BOTTOM RUNGS OF HAWAII'S SOCIO-ECONOMIC STRATA. IN THE MIDST OF A STATE POPULATION ENJOYING THE HIGHEST LEVELS

OF PHYSICAL HEALTH, NATIVE HAWAIIANS SUFFER ALARMINGLY POOR HEALTH BELOW BOTH OUR STATE AND NATIONAL NORMS. I WILL LEAVE IT TO THE EXPERTS PRESENT TODAY TO TESTIFY IN MORE DEPTH ON THE RESULTS OF THIS HEALTH STUDY. BUT THE PICTURE OF THE NATIVE HAWAIIAN PEOPLE DEPICTED BY THIS STUDY WAS ENOUGH TO HIGHLIGHT ONCE AGAIN THE IMPORTANCE OF THE FEDERAL GOVERNMENT AGGRESSIVELY PURSUING ITS UNIQUE RESPONSIBILITY TO THESE NATIVE AMERICAN PEOPLES.

I URGE THE SUPPORT OF MY COLLEAGUES FOR THIS VITAL LEGISLATION. I THANK THOSE WHO HAVE COME SO FAR TO OFFER TESTIMONY AND ALSO THOSE NOT HERE TODAY WHO GAVE THEIR SUPPORT AND EXPERTISE TO THE COMPLETION OF THIS STUDY.

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STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HAWAII 96801

PREPARED STATEMENT OF
LESLIE S. MATSUBARA
DIRECTOR OF HEALTH
BEFORE THE
SELECT COMMITTEE ON INDIAN AFFAIRS
ON MAY 7, 1986
REGARDING THE
HEALTH STATUS OF NATIVE HAWAIIANS

THE HAWAII DEPARTMENT OF HEALTH IS TRULY APPRECIATIVE OF THIS OPPORTUNITY TO TESTIFY IN SUPPORT OF S. 2243, A BILL TO IMPROVE THE HEALTH STATUS OF NATIVE HAWAIIANS.

THE FINDINGS OF THIS BILL OUTLINE SOME OF THE ASTOUNDING REALITIES REGARDING THE HEALTH STATUS OF NATIVE HAWAIIANS. ACCUMULATING DATA HAS CONVINCINGLY CONFIRMED THE VALIDITY OF THESE GROWING CONCERNS ABOUT THE EXTENT OF UNIQUE PROBLEMS WITHIN THIS SPECIAL POPULATION. CAST IN THE BACKDROP OF HAWAII'S GENERAL POPULATION, WHICH USUALLY COMPARES POSITIVELY ON MOST HEALTH INDICATORS, NATIVE HAWAIIANS FARE POORLY OVER A WIDE SPECTRUM OF PHYSICAL, EMOTIONAL, SOCIAL, AND FUNCTIONAL DIMENSIONS.

ALTHOUGH THE DEPARTMENT HAS RECOGNIZED MANY ASPECTS OF THESE UNIQUE HEALTH PROBLEMS IN THE PAST, IT HAS NOT BEEN EASY TO ASSEMBLE THE RELEVANT AND EFFECTIVE PREVENTION AND INTERVENTION APPROACHES, OR NECESSARY RESOURCES, TO TAILOR A CONCERTED EFFORT ON BEHALF OF THE NATIVE HAWAIIAN POPULATION. SEVERAL SIGNIFICANT PILOT AND DEMONSTRATION PROJECTS HAVE BEEN INITIATED BY THE DEPARTMENT WITH SOME SUCCESSFUL RESULTS. HOWEVER, WE RECOGNIZE THAT MUCH MORE NEEDS TO BE DONE.

FROM A PUBLIC HEALTH PERSPECTIVE, OUR FUNDAMENTAL CONCERN IS THAT WITHOUT A MORE WIDESPREAD AND CONCERTED COMMUNITY WIDE EFFORT, THERE IS A REAL POTENTIAL FOR PERPETUATION AND INTENSIFICATION OF THESE PROBLEMS EFFECTING MANY DIMENSIONS OF LIFE FOR NATIVE HAWAIIANS AND THE POPULATION OF OUR STATE GENERALLY.

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FOR THESE REASONS, THE HAWAII DEPARTMENT OF HEALTH STRONGLY ENDORSES THIS BILL WHICH CLEARLY SEEKS TO ACHIEVE A MAJOR AND BROAD IMPACT UPON NATIVE HAWAIIAN HEALTH PROBLEMS.

WE MAKE TWO RECOMMENDATIONS:

1. WHILE WE AGREE THAT NATIVE HAWAIIAN ORGANIZATIONS SHOULD BE THE PRIMARY PARTICIPANTS IN CARRYING OUT THE PROPOSED ACTIVITIES OF THIS BILL, WE RECOMMEND THAT AN APPROPRIATE STATE GOVERNMENT ENTITY BE DESIGNED TO OVERSEE AND ADMINISTER THESE GRANTS. THE HAWAII DEPARTMENT OF HEALTH IS WILLING TO PLAY WHATEVER ROLE WOULD BE HELPFUL. THE REASONS FOR THIS RECOMMENDATION ARE AS FOLLOWS:

   a. THIS IS A FAR REACHING, STATEWIDE EFFORT WITH MUCH POTENTIAL FOR PUBLIC IMPLICATIONS AND ACCOUNTABILITY, AND THEREFORE OVERSIGHT SHOULD BE LOCATED WITHIN A STATE GOVERNMENTAL AGENCY.

   b. THIS LOCAL CENTRALIZED OVERSIGHT ARRANGEMENT WOULD ALLOW THE PARTICIPATION OF VARIOUS NATIVE HAWAIIAN ORGANIZATIONS.

   c. BECAUSE OF THE DEVELOPMENTAL, EDUCATIVE, TRAINING, AND EVALUATIVE ASPECTS OF THESE GRANTS, THE UNIVERSITY OF HAWAII, SUCH AS THE SCHOOL OF MEDICINE OR POSSIBLY THE SCHOOL OF PUBLIC HEALTH, SHOULD BE INVOLVED FOR ITS CLINICAL AND SCIENTIFIC EXPERTISE AND OPPORTUNITIES TO INTERCHANGE TECHNICAL KNOWLEDGE WITH OTHER RELEVANT UNIVERSITIES THROUGHOUT THE COUNTRY.

2. THE ACT SHOULD REQUIRE THE FORMATION OF AN ADVISORY BOARD TO THE GRANTEE(S), REPRESENTATIVE OF ALL INTERESTED PARTIES IN HAWAII, FOR PURPOSES OF ASSISTING THE APPROPRIATE DEVELOPMENT AND PROGRESS OF THESE PROJECTS.

THE HAWAII DEPARTMENT OF HEALTH URGES THE COMMITTEE ON INDIAN AFFAIRS' SUPPORT OF S. 2243 AND OFFERS ITS ASSISTANCE IN WHATEVER WAYS TO ASSIST CONGRESS TO ACHIEVE THE PURPOSES OF THIS BILL.

Prepared Statement Of

Winona Kealamapuana Ellis Rubin
Chief Executive Officer, ALU LIKE, Inc.
Honolulu, Hawaii

Aloha, Mr. Chairman and members of the Committee. I am Winona Kealamapuana Ellis Rubin, Chief Executive Officer of ALU LIKE, a private non-profit, community-based organization. ALU LIKE administers the Native Hawaiian Program established under Title VIII of the Native American Programs Act. It provides the enabling mechanism for promoting the goal of economic and social self-sufficiency for Native Hawaiians. As part of our continuing efforts to meet the needs of the Native Hawaiian community, ALU LIKE has investigated the health needs in the Native Hawaiian population, and has formed and coordinated the Native Hawaiian Health Research Consortium to address these needs.

This Consortium includes members from Native Hawaiian institutions and agencies and from public and private research, educational, and health institutions and agencies. The Consortium has completed a Native Hawaiian Health Needs Study Report (E OLA MAU) which was prepared for the Department of Health and Human Services in response to a request from the Senate Appropriations Committee. The scope of the Report focused on five Task Force areas, namely, Medical, Mental Health, Nutrition/Dental Health, Historical/Cultural, and Strategic Health Plan. It is from the

perspectives of these Task Forces that members of this Panel will present their testimonies (see Attachment 1 for list of panelists). I will be addressing Section 3 of this Bill pertaining to Health Promotion and Disease Prevention, Section 4 on Community Health Centers and National Health Service Corp. Program, and Section 7 on Access to Medicare and Medicaid Services, from the perspective of the Medical Task Force. Others on this Panel will be addressing the remaining portions of the Bill.

Section 3 states that "The Secretary shall, in consultation with Native Hawaiian organizations, establish a program of health promotion and disease prevention designed to serve the Native Hawaiian population." It further specifies that this program shall "provide necessary preventive-oriented health services, including maternal and child health care and mental health care." This comprehensive approach to preventive program will conserve limited financial and personnel resources since it will reduce the number of serious health problems in the Native Hawaiian population through early detection and therapy.

The provision, in Section 3(B), for "the collection of data related to the prevention of diseases and illnesses among Native Hawaiians including fetal alcohol syndrome, hypertension, heart disease and diabetes," is important since, at present, the measures of incidence and prevalence of these illnesses is not adequate. This is also important since the establishment of baseline data is the only way the effectiveness of preventive programs can be determined - also the prioritization of programs should be based upon adequate incidence/prevalence data. The collection of data can be accomplished through sample surveys, screening programs and other

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surveillance in cooperation with providers of health services. Additional research can study the risk factors associated with these diseases. This will optimize the resource expenditures since services can be offered and established in areas where Native Hawaiians at high risk are located. Evaluation of intervention can be made along with the provision of services in order to determine effectiveness, cost/benefit ratios, changes in quality of life, and other factors as the preventive programs are implemented.

Section 3(C) includes a provision "for medical and general health-related research into diseases that are most prevalent among Native Hawaiians, including but not limited to, heart disease, hypertension, cancer, diabetes." These are the most prevalent diseases among Native Hawaiians, and Native Hawaiians experience greater prevalence in these disease than do other groups (see Attachment 2 for details). It is important to improve the available data on incidence and prevalence of illness in order to establish priorities and to conduct research on risk factors in order to plan preventive programs. It is also important to have ongoing monitoring and surveillance on various diseases in order to evaluate progress in preventive programs and in order to reassess priorities. The establishment of ongoing data collection and research allows for continuous monitoring of effectiveness as well as changes in prevalence patterns which can be the basis for establishing priorities and planning implementation of services.

Regarding Section 4 on Community Health Centers and the National Health Service Corp. Program, the Consortium recognizes the need to stimulate existing private and public health care delivery systems to more effectively respond to the health needs of

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Native Hawaiians.

Private sector medicine will increase its responsiveness as more Native Hawaiians enter the health professions. This requires a systematic effort to recruit and train Native Hawaiian medical candidates, and to assist them in establishing practices in Hawaiian communities. Local professional associations, educational institutions, and voluntary agencies provide often untapped resources. Existing federal programs such as the National Health Service Corps can be utilized to maximize educational opportunities for Native Hawaiians, and to effectively relocate medical manpower to high need Hawaiian communities. (American Indians and Eskimos are already designated as "Health Manpower Shortage Area" population groups.) This Bill would recognize Native Hawaiians as a Health Manpower Shortage Area population group, as well.

It should be recognized that unique and significant health problems do exist in many Hawaiian communities. In such areas, where there is a shortage of health manpower or a large uninsured population, or where extensive health problems exist that require comprehensive intervention strategies, new health resources must be developed.

In reviewing potential models for augumenting existing health resources, the Consortium supports the use of the Community Health Center Program (PHS Section 330). The Community Health Center Program offers the following advantages:

1. It is predominately community-based, enabling a high degree of local automony.
2. It maximizes the potential of public and private resources, including volunteers.

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3. It has gained bipartisan support in both houses of Congress, has recently received Congressional reauthorization, and has retained a high degree of stability even in difficult budget periods.
4. It has proved to be a highly efficient program which has leveraged services valued at more than twice as much as the federal grant funds involved.

In order to adapt PHS 330 funding criteria to Hawaii, Hawaiian geographic conditions must be considered (entire islands are often a single census tract). This Bill allows for Medically Underserved Area designation for Native Hawaiian communities, enabling them to seek 330 funds.

This Bill can, for a modest investment, go a long way to improving the health status of Native Hawaiians. It can do so efficiently by tapping both private and public resources, utilizing existing channels of federal support, and by cultivating the creative energies inherent in local Native Hawaiian communities. This legislation will give Native Hawaiians the opportunity to develop resources and maintain responsibility for their own health.

Section 7, regarding Access to Medicare and Medicaid Services, states that "The Secretary should, in consultation with Native Hawaiian organizations, conduct a study of any barriers which may exist to the participation of Native Hawaiians in programs established under title XVIII of the Social Security Act (medicare) or under title XIX of the Social Security Act (medicaid)." In order to increase the accessibility of these programs to Native Hawaiians, it is important to understand why there are barriers which prevent Native Hawaiians from participation. This can be achieved by

understanding Hawaiian cultural values and perceptions of Native Hawaiians regarding, not only accessibility, but availability and acceptability of services. It is also important to investigate ways in which these barriers can be ameliorated. This can best be done through demonstration projects which can test various means of improving access.

From the scant data on medicare and medicaid participation available for Native Hawaiians, they seem to participate less than the general population. Research on the extent and types of third-party insurance coverage as well as medicare and medicaid participation will facilitate planning for improved access to medical services. Further research can study the number of Native Hawaiians who participate in, as well as the potential number of Native Hawaiians who might participate in, medicare and medicaid programs. This allows program planners to determine the resources necessary to meet current demand as well as potential demand for services.

Finally, this Bill specifically targets federal investment to Native Hawaiians, and in no way jeopardizes or dilutes the funds and resources already going to other Native American groups.

Thank you for giving us the opportunity to make these presentations in support of S.2243.

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Attachment 1

E OLA MAU

Native Hawaiian Health Research Consortium

Order of Panel Presentations

Winona Rubin Chief Executive Officer ALU LIKE, Inc. Honolulu, Hawaii	Presenting for the Consortium; focusing on the Medical Task Force Report
Naleen Andrade, M.D. Psychiatry Division Queen's Hospital Honolulu, Hawaii	Presentation focusing on the Mental Health Task Force Report
Claire Hughes, Chair Committee on Health Concerns Assoc. of Hawaiian Civic Clubs Honolulu, Hawaii	Presentation focusing on the Nutrition/Dental Health Task Force Report
Emrett Aluli, M.D. Molokai Heart Study Kaunakakai, Hawaii	Presentation focusing on the Historical/Cultural Task Force Report
Ormond Hammond, Director Planning & Evaluation Office The Kamehameha Schools Honolulu, Hawaii	Presentation focusing on the Strategic Health Plan Task Force Report

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Attachment 2

CHAPTER III. AN OVERVIEW OF ETHNIC COMPARISONS IN HAWAII

This chapter provides an overview of the Moroidity and Mortality experience among Native Hawaiians, including Hawaiians (who have pure ancestry) and Part-Hawaiians (those who have mixed ancestry).

The purpose of this chapter is to describe the incidence and prevalence oi Morbidity and Mortality by cause in order to make some inferences about the health status and the health needs of Native Hawaiians. Comparisons of Native Hawaiians will be made with the other major ethnic groups in Hawaii in order to provide some perspective and in order to evaluate and interpret the Native Hawaiian morbidity and mortality experience. Other sections of this report will focus on specific conditions, such as cancer, hypertension, and diabetes which are among the more serious conditions Native Hawaiians experience. This chapter will identify other serious conditions which need attention, and even though a detailed discussion of these additional conditions will not be made, some evaluation of the importance of these conditions will be given.

The tables which present the data refer to three different categories of persons with Hawaiian ancestry. Hawaiians are those who are not mixed with other ethnicity. Part-Hawaiians are those who have Hawaiian ancestry mixed with some other ethnicity. The term Native Hawaiians refers to the combination of these two categories. Other ethnic categories in the data include those who report parentage only from that ethnicity, except for the "Other/Unknown" category which includes all the minor ethnicities and those who have mixed parentage, except for those mixed with Native Hawaiian. If we are to compare Native Hawaiians with other

ethnicities, it is most appropriate to compare the "Hawaiian" or pure category with the other groups since they too include only those who have one ethnicity. However, it is estimated that among Native Hawaiians (Johnson, 1983) only 9,000 persons in the State are pure Hawaiian while some 50,000 persons in the State have at least half Hawaiian blood. The other 130,000 persons with Hawaiian ancestry have less than half Hawaiian blood. This report will maintain the distinction between two sub-categories of Native Hawaiians: Hawaiians (pure Hawaiian ancestry), and Part-Hawaiians (mixed Hawaiian ancestry) in order to facilitate the explanation and evaluation of the mortality and morbidity experience of Native Hawaiians (both groups combined).

A. MORTALITY

Mortality is an important indicator of health in a population. The causes of mortality provide a picture of the kinds of medical and non-medical reasons for death. These are important since they provide an indication of the kinds of problems which lead to death and which might be areas of concern. Death caused by accidents or suicide or some other preventable illness condition might be averted with appropriate intervention. This section provides a picture of the kinds of causes which contribute to death, as well as the distribution of deaths by ethnicity, age and gender. The ethnic comparisons are valuable in showing how Native Hawaiians fare mortality-wise and provide clues for improvement of the mortality situation among Native Hawaiians.

The causes of mortality are those utilized by the national and state vital reports. Definitions of these causes can be obtained from the reports published by the Hawaii State Department of

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Health's, Vital Statistics Office.

Registration of death has been practiced in Hawaii since 1908. In reveiwing the mortality trends since 1910, Native Hawaiians have experienced the highest age-sex standardized mortality rates of any major ethnic group in Hawaii (Table 6, Research and Statistics Report #2), with a downward trend experienced for all ethnic groups (Figure 1, Research and Statistics Report #38).

Part-Hawaiians have experienced mortality rates somewhat similar to non-Hawaiians, with Hawaiians experiencing much higher rates than other groups. The mortality rates for cancer and heart disease have increased over time with mortality caused by infectious diseases on the decline (p.4, Research and Statistics Report #38). Mortality from hypertension, heart disease, arteriosclerosis and diabetes have increased markedly between 1920 and 1960 with a decline since that time. For mortality caused by cancer, Native Hawaiian males were the highest of all groups and were among the highest for cancer of the stomach, with the lowest survival rate from colon cancer. Native Hawaiian females had the highest mortality rates for cancer of the breast and cervix. The sums of rankings of age-standardized mortality from all cancer sites in 1968-72 and 1978-80 were highest among Native Hawaiians.

Another indicator of mortality is life expectancy, historically Native Hawaiians have had among the lowest life expectancy at birth, ranging from five to ten years less than the overall population average during the period from 1910 through 1970 (Table 1, Research and Statistics Report #26). The most recent life tables for 1980 show Native Hawaiian life expectancy at birth about five years less than the total population of the State (p.5, Research and Statistics

Report #47).

In recent years (1980-84) Native Hawaiians are experiencing higher death rates than non-Hawaiians. Part-Hawaiians, while higher than non-Hawaiians, have lower mortality overall than Hawaiians, even after adjusting for age (see Table III-1).

Accidental deaths are highest for Hawaiians (46.3 per 100,000) than for Part-Hawaiians (30.1 per 100,000) who in turn are higher than non-Hawaiians (27.8 per 100,000). Motor Vehicle accidents comprise the vast majority of accidental deaths for Native Hawaiians, even a higher proportion than for non-Hawaiians. The next most frequent kind of accidental death is from drowning, particularly for the younger Native Hawaiians (see Appendix A, Table IVA on Deaths by Cause, Age and Ethnicity).

Other kinds of non-medical causes of death are suicide and homicide. While these two causes of death were relatively infrequent, Hawaiians had higher rates of death from Suicide than non-Hawaiians and Native Hawaiians had higher rates of death from homicide than non-Hawaiians (see Table III-1).

Table III-2 shows the rankings of the top ten causes of death within each ethnic category. Overall, the diseases of the heart ranked the highest; however, diabetes was ranked highest for Part-Hawaiians and non-Hawaiians. Hypertensive heart disease was the second highest cause of death for Part-Hawaiians and non-Hawaiians. Ischemic heart disease was the highest and other heart diseases were the next to highest cause of death for Hawaiians and Native Hawaiians.

Other diseases were ranked third and fourth. This category includes a number of different diseases, each of which alone would

not be an important cause of death.

While diabetes was the most frequent cause of death for Part-Hawaiians and non-Hawaiians, it ranked ninth for Native Hawaiians and seventh for Hawaiians and an overall ranking of sixth.

Malignant neoplasms (cancer) was another important cause of death. Cancer of the digestive organs (such as stomach, bowel, etc.) ranked fourth and fifth. Cancer of the respiratory system (such as lungs) was ranked fifth through eighth overall. Leukemia was ranked fifth overall and other kinds of cancer were ranked ninth overall.

In looking at the rankings for Native Hawaiians and non-Hawaiians we can see that between heart disease, cerebrovascular disease, hypertension, cancer and diabetes which were the highest ranking causes of death there is a general congruence. Diseases of the circulatory system are generally the highest, then cancer, then diabetes. There are some differences when focusing upon specific diseases and upon sub-categories of Native Hawaiians. This kind of ranking allows us to see the order of importance of different causes of death within each ethnic category or sub-category.

Table III-3 shows the rankings of different ethnic categories on each cause of death. Overall, there is a lot of consistency, with Hawaiians having the highest ranking (meaning the highest age-adjusted rates) and Native Hawaiians second, Part-Hawaiians third and non-Hawaiians fourth. Non-Hawaiians rank higher than Hawaiians only on hypertension. Within the category of Native Hawaiian, Part-Hawaiians rank higher than Hawaiians on hypertension, leukemia, diabetes and hypertensive heart disease. Hawaiians ranked higher than Part-Hawaiians on all other causes of death. These

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rankings are based upon age-adjusted mortality rates for each ethnic group and so differences in the age distribution of the different ethnic categories have no effect on these rankings. Thus, these findings are considered to be a reliable indication of the most important causes of death and how Native Hawaiians compare with non-Hawaiians.

B. MORBIDITY

Morbidity is the presence of acute or chronic illness, accidents and injuries. This section will show the distribution of morbidity within the Native Hawaiian population and between Native Hawaiians and other ethnic groups living in Hawaii. The sections on acute and chronic morbidity will summarize the available data over time with emphasis upon the recent period. Detailed tables of the recent data are available in Appendix A, Tables II, III and V series.

Acute Conditions

Acute conditions differ from chronic conditions in terms of type and duration. For our purposes acute conditions are those whose duration is less than three months and chronic conditions are those whose duration is greater than three months. The general types of acute conditions are infectious and parasitic, respiratory, digestive, and injuries. Respiratory conditions can be either acute or chronic, depending upon duration. This is also true of digestive conditions. Injuries are generally acute, whereas impairments are oftentimes the chronic effects of injuries or accidents.

Tables III-4 and III-5 illustrate the rates of acute conditions for different ethnic groups. In order to summarize these rates, Tables III-6 and III-7 show rankings of these rates. Table III-6

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shows how the acute condition rates are ranked within each ethnic group. There is considerable agreement among the different ethnic groups regarding these rankings. For example, upper respiratory conditions are ranked as number one, meaning that they have the highest incidence. Second are "other" acute conditions, third is influenza for most groups, fourth are injuries, although there is less agreement, fifth are infectious and parasitic conditions, sixth are "other" respiratory and seventh, with complete agreement, are digestive conditions.

Within the Native Hawaiian categories there are only two conditions which are ranked differently for Hawaiians and Part-Hawaiians and they are influenza and injuries. Influenza is ranked higher (3) for Part-Hawaiian compared with fourth for Hawaiians. Injuries are ranked higher for Hawaiians (3) compared to fourth for Part-Hawaiians. Overall, Native Hawaiians do not appear to differ from other ethnic groups nor do subgroups of Native Hawaiians differ from the overall Native Hawaiian group regarding the distribution of acute conditions. It appears that upper respiratory conditions are overwhelmingly high for all ethnic groups in Hawaii. This is consistent with the high prevalence rates for hayfever, asthma, and bronchitis in the chronic conditions discussed below.

In Table III-7 the rankings are made of the acute condition rates across each ethnic group for each condition separately. Where rates are identical the rankings are shared. Generally, Part-Hawaiians have higher rankings than average and Hawaiians have lower rankings than average. Part-Hawaiians are highest on respiratory conditions compared to Hawaiians who were low on all but the "other" category of acute conditions. This finding contrasts

with the prevalence rates for Hawaiians and Part-Hawaiians, in which Hawaiian prevalence rates were generally higher than for Part-Hawaiians (for most conditions). Acute conditions generally affect younger populations more and chronic conditions generally affect older populations more. Hawaiians, being generally older, experience higher prevalence of chronic conditions and Part-Hawaiians, being generally younger, experience higher incidence of acute conditions.

In addition to the above observations, Table III-5 illustrates the distribution of acute condition rates within the subgroups and genders for Native Hawaiians. As indicated in the previous discussion, Part-Hawaiians generally have higher incidence rates than Hawaiians. Also, females generally have higher rates than males. The latter observation is true for all acute conditions except for "other" respiratory, digestive conditions, and injuries. In these latter conditions, male rates are higher than female rates for "other respiratory" and digestive conditions among Hawaiians and for injuries among Part-Hawaiians.

Chronic Conditions

As mentioned above, chronic morbidity refers to long term illness and impairments. Data on chronic morbidity show that over the past two decades Native Hawaiians have experienced higher rates of chronic illness than have other groups. In terms of hospitalization and days spent in bed due to illness, Native Hawaiians were higher than other groups.

Specifically, a 1972 and a 1980 report show an inverse relationship between income and chronic illness and hospitalization and that Native Hawaiians have among the highest rates of chronic

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illness and hospitalization (Research and Statisics Reports #19 and #31). A 1978 study shows higher than expected age-sex standardized rates of heart disease, hypertension and cerebrovascular disease. Chinese, Filipinos and Japanese have lower than expected rates (Research and Statistics Report #23, Tables 3 and 4). This same report shows that Native Hawaiians have the highest ranking of any group on selected chronic conditions, number of days spent in bed due to illness and number of hospital nights. A 1982 study shows that Native Hawaiians have the highest mortality (Research and Statistics Reports, #38).

Current Morbidity Among Native Hawaiians

In looking at the age-specific rates of some twenty chronic conditions in Appendix A, Table IIB, we can observe that among Native Hawaiians and for each gender group (males/females) those who are older have higher prevalence than those who are younger. This is also true for all other ethnic groups in the State.

Age is an important factor in determining the kinds and frequency of illness, i.e., older ages have more chronic conditions than do younger ages. When comparing the incidence and prevalence of morbidity among different groups it is important to consider the differences in the age distributions. For this reason the prevalence rates of some twenty chronic conditions have been standardized to the overall State age distribution, permitting a more meaningful comparison of their rates between Native Hawaiians and the other ethnic groups. This comparison is shown in Appendix A, Table IIB.

It is important to understand the age-specific unadjusted rates

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for the different Native Hawaiian categories in order to appreciate the effects of the age distribution and age-standardization upon the rates. Table III-8 shows the unadjusted and adjusted prevalence rates of the eleven most prevalent chronic conditions (also see Appendix A, Table IIB). As mentioned above, older ages have higher prevalence rates than do younger ages. Also, Hawaiians have higher overall rates (795.0 per 1000) than do Part-Hawaiians (510.7 per 1000). Within each of these categories, females have higher rates than do males, i.e., Hawaiian females (808.0), Hawaiian males (781.5); Part-Hawaiian females (524.2), Part-Hawaiian males (497.3).

Impairments are suffered more by Native Hawaiian males than females, whereas arthritis and rheumatism are suffered more by females than males. Respiratory conditions such as asthma, hayfever, sinusitis and bronchitis/emphysema are suffered more by females than males. Heart conditions are suffered more by males than females. high blood pressure and diabetes are higher among Hawaiian males and lower among Part-Hawaiian males.

Hawaiians

When looking at specific illness conditions we see that high blood pressure (120.9), heart conditions (71.8), diabetes (69.2), arthritis and rheumatism (50.8), and impairment of back and spine (50.0) are the most prevalent for Hawaiians. When comparing males and females within this category we can see that both genders are highest on high blood pressure (Males=117.3, Females=124.3), with females having a higher prevalence than do males. Next are heart conditions (75.2), diabetes (71.1), impairment of back and spine (63.0) and hearing impairments (61.1) for males. In contrast, females have a much higher prevalence of arthritis and rheumatism

(77.7), and asthma (70.0); with heart conditions (68.6) and diabetes (67.4) lower than males.

Looking at the effects of age-adjustment of the Hawaiian rates, the age-adjusted rates show high blood pressure (82.1 compared to 120.9 unadjusted), heart conditions (49.4 compared to 71.8 unadjusted), diabetes (44.2 compared to 69.2 unadjusted), asthma (42.6 compared to 41.6 unadjusted) and impairment of back and spine (41.8 compared to 50.0 unadjusted) to be the highest for Hawaiians. For males it changes slightly to high blood pressure (83.4 compared to 117.3 unadjusted), heart conditions (55.7 compared to 75.2 unadjusted), impairment of back and spine (50.2 compared to 63.0 unadjusted), diabetes (47.7 compared to 71.1 unadjusted) and hearing impairments (38.2 compared to 61.1 unadjusted). For females it changes to asthma (80.5 compared to 70.0 unadjusted, high blood pressure (79.0 compared to 124.3 unadjusted), arthritis and rheumatism (42.4 compared to 77.7 unadjusted), heart conditions (41.7 compared to 68.6 unadjusted), and diabetes (40.4 compared to 67.4 unadjusted).

The age-adjustment generally lowered the prevalence rates for Hawaiians, meaning that Hawaiians, being older than the average for the Native Hawaiian population, generally have higher rates than the Part-Hawaiian group which have a younger population. In some instances the effect of controlling the age distribution are higher, rather than lower rates. For instance asthma and impairments of back and spine rates. This might mean that these two conditions are more prevalent in younger populations and when age-adjusting the rates for Hawaiians who are older to the age distribution of the total population, it had the effect of increasing the Hawaiian

rates. The important thing to remember about age-adjustment is that it enables a comparison of different groups/categories of the population, becauses it erases or controls for the effect of differences in age. Now let us look at the prevalence rates for the Part-Hawaiian group.

Part-Hawaiians

Part-Hawaiians experience their highest prevalence with asthma (57.9 per 1000), high blood pressure (51.7), hayfever (42.2) and impairment of back and spine (38.1). Males have asthma (53.4), high blood pressure (50.4), impairment of back and spine (43.7), and hayfever (35.3). Females have asthma (62.4), high blood pressure (53.0), hayfever (49.1) and impairment of back and spine (32.4). Thus, Part-Hawaiians have a different set of high prevalence conditions than Hawaiians, due in part to the difference in their age distribution. Within the Part-Hawaiian group, male and female rates are high for similar conditions, although female rates are higher for asthma, high blood pressure, and hayfever and lower for impairment of back and spine. The higher rates for impairment of back and spine among males is probably due to differences in major activity (i.e., occupation). Now we will see how the control of differences in age distribution affect the prevalence rates.

The age-adjusted rates for Part-Hawaiians show high blood pressure (87.6 compared to 51.7 unadjusted), asthma (54.0 compared to 57.9 unadjusted), impairment of back and spine (49.5 compared to 38.1 unadjusted), and hayfever (43.7 compared to 42.2 unadjusted). Thus, the effects of the control of age are mixed with the age-adjusted rates for high blood pressure, impairment of back and

spine and hayfever increasing and asthma decreasing. This indicates that Part-Hawaiians, having a slightly younger than average population, have fewer illnesses associated with aging and more illnesses associated with younger ages.

The effects of controlling for age produced some changes in the rates for females: high blood pressure (90.6 compared to 53.0 unadjusted), asthma (62.8 compared to 62.4 unadjusted), hayfever (53.3 compared to 49.1 unadjusted), impairment of back and spine (40.2 compared to 32.4 unadjusted) and arthritis (36.4 compared to 20.6 unadjusted). Generally the effect was to reduce the rate, meaning that when Part-Hawaiian females age is the same as for the total population, their rates of chronic conditions is lowered.

The effects of controlling for age also produced some changes in the rates for males: high blood pressure (84.1 compared to 50.4 unadjusted), impairments of back and spine (58.9 compared to 43.7 unadjusted), asthma (45.0 compared to 53.4 unadjusted), hayfever (33.9 compared to 35.3 unadjusted) and heart conditions (32.1 compared to 18.2 unadjusted). For three of these five conditions, i.e. high blood pressure, impairment of back and spine and heart conditions, the effect of age-adjustment was to reduce the rate. For the other two conditions, i.e. asthma and hayfever, the effect was to increase the rate.

Comparison of Native Hawaiians With Other Ethnicities

In addition to understanding the distribution of chronic morbidity within the different genders and subgroups of Native Hawaiians it is important to compare Native Hawaiians with non-Hawaiian ethnicities. This allows an evaluation of the age-adjusted chronic morbidity rates for Native Hawaiians. Tables

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III-9 and III-10 have been summarized from Appendix A, Table IIB. Instead of using rates, these tables utilize rankings of the age-adjusted rates from Appendix A, Table IIB. The rankings in Table III-9 run vertically within some 20 chronic conditions, showing for each ethnic category which chronic condition has the highest rate (rank 1) all the way to that which has the lowest rate (rank 20). Where two conditions have the same rate, they share the same rank.

In general, high blood pressure is ranked number 1 for all but one ethnic group, i.e., Caucasians. Hayfever is ranked overall number 2, with impairment of back and spine number 3, then asthma (4), hearing impairments (5), arthritis (6), chronic allergic skin condition (7), chronic sinusitis (8), heart conditions (9) and diabetes (10). For Native Hawaiians there is agreement with the top ranked condition, however second ranked is asthma, then impairment of back and spine (same as overall), hayfever (4), diabetes (5), heart conditions (6), hearing impairments (7), arthritis (8), chronic allergic skin condition (9) and bronchitis (10). Thus, heart conditions, asthma and diabetes are ranked higher for Native Hawaiians than for the overall population. This is an indication that these conditions may be a greater problem among Native Hawaiians than among non-Hawaiians.

When comparing Hawaiians with Part-Hawaiians we see that both subgroups share high blood pressure as the highest ranked condition. Hawaiians then differ with heart conditions (2), diabetes (3), asthma (4), impairment of back and spine (5), arthritis and rheumatism (6), hearing impairment (7), hayfever (8), bronchitis/emphysema (9) and gout (10). Part-Hawaiians, being much

larger in number, were similar to the Native Hawaiian category. As we can see from these differences in rankings, Hawaiians have higher rates of problems associated with older ages than do Part-Hawaiians. Hawaiians for the more part seem to have high rankings in conditions which are associated with diet, such as high blood pressure, diabetes, gout, and heart conditions. In addition, Hawaiians appear to be high in impairments of back and spine and in hearing. Some of the chronic respiratory conditions appear to affect the Hawaiian population heavily, such as asthma, hayfever and bronchitis/ emphysema.

Table III-10 contrasts with Table III-9 in that it illustrates the relative importance of each chronic condition across the spectrum of ethnic groups, rather than within each ethnic group. From Table III-10 we can expect to discover which conditions are comparatively high, medium or low in prevalence for the Native Hawaiian groups. In order to facilitate this, the rightmost column of Table III-10 summarizes the relative prevalence of each condition listed in the Table for the Native Hawaiian groups as a whole.

Those chronic conditions which are "high" compared to the other ethnicities are heart conditions, high blood pressure, asthma, diabetes, and gout. In addition, those chronic conditions which are "high/medium" are malignant neoplams, bronchitis/emphysema, and varicose veins. This list of chronic conditions overlaps the list obtained from Table III-9, thus, verifying their greater importance for Native Hawaiians than for other non-Hawaiian ethnic groups. This does not mean that other groups should not be concerned about them, it simply means that Native Hawaiians are justified in being more concerned than other groups since the prevalence of these

conditions is higher among Native Hawaiians than others.

By contrast, Native Hawaiians need not be as concerned about those chronic conditions which are evaluated "low", such as stomach ulcer, hemorroids, etc. Other groups might indeed find these conditions of greater concern than Native Hawaiians.

Within the Native Hawaiian groups, it appears that Hawaiians have a higher ranking than Part-Hawaiians on heart conditions, diabetes, malignant neoplasms, goiter and varicose veins. Part-Hawaiians, by contrast, have higher rankings on impairment of back or spine, high blood pressure, hearing impairments, asthma, bronchitis/emphysemsa, and gout. Part-Hawaiians seem to have higher prevalence of impairments and respiratory conditions. Hawaiians have higher prevalence of chronic conditions associated with age. Both have a high prevalence of conditions associated with diet, such as diabetes, high blood pressure, and gout.

C. EFFECTS OF MORBIDITY

Previous discussion has been primarily concerned with the incidence and prevalence of chronic and acute morbidity conditions in the Native Hawaiian population which provides a picture of the distribution and extent of morbidity. Another dimension of morbidity is that of its impact upon the Native Hawaiian population in terms of limiting the kinds or amount of activities usually engaged in, that is, activity limitation (see Table III-11). Another indicator of this dimension is whether or not a specific condition is limiting a person's ability to engage in their usual activities (see Tables III-12 and III-13). This is important since in many instances where a person is limited in his/her usual activities there may be more than one condition present. It is

useful to know which of those conditions cause the limitation. A third indicator of the impact of morbidity might be the number of days persons stay away from school (for children), or work (for working ages) due to illness. A fourth indicator is the number of days persons must remain in bed all or most of the day due to illness. These latter indicators have not been associated with any specific illness or morbidity conditions (see Table III-14).

Table III-11 illustrates the extent of activity limitation by chronic condition for Native Hawaiians. There are four categories of limitation, the most severe limitation is, "Unable to carry on major activity", which means that the person cannot work, go to school or keep house or do any of the other major activities they normally would be able to do. The second most severe category of limitation is when the person is, "Limited in the amount or type of major activity" which means that they can still perform a major activity but are restricted in the kind of activity or in the extent of their participation in it. The third most severe category of limitation indicates a reduction in limitation since the person is, "Limited but not in major activity", which means they can perform any major activity they want, such as work, keep house, etc., but they nevertheless suffer some restriction in what they can do otherwise. The least severe limitation is "No limitation of activity".

For our discussion here we have taken the most severe category of limitation, "Unable to carry on major activity" and show the percentages for the total population and for each category of Native Hawaiians in the first part of Table III-11. The second part of the Table shows the least severe limitation category, "No Limitation of

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Activity" for each chronic condition and for the total population and for each category of Native Hawaiians.

In looking at the total population, first we can see that the highest percentages in the "Unable" category are malignant neoplasms (17.1%), then visual impairments (13.3%), heart condtions (11.6%), mental and nervous conditions (11.2%), other (9.5%), arthritis and rheumatism (8.3%), diabetes (7.9%), hearing impairments (6.9%) and bronchitis/emphysema (6.7%). Overall, among all chronic conditions, some 6.2% report being unable to carry on a major activity.

As we know from previous discussion, some of these conditions are not as prevalent as others which are less limiting. This means that while some chronic illnesses are rather common, they do not limit a person's usual activity in a serious way. For example, we can see that some 83.6% of persons with high blood pressure have no limitation at all, even though this is the most common chronic condition. Another common condition is hayfever and yet 92.4% of those who have this condition report no limitation. For persons with impairment of back or spine, some 73.0% say they have no limitation. For persons with hearing impairments, some 74.0% have no limitation. For persons with asthma, some 86.6% say they have no limitation. In fact, overall for all chronic conditions combined, some 75.7% report no limitation.

When comparing Native Hawiians with the total population we can see that for all conditions combined there is little difference in the percentages who are unable to carry on their major activity. However, we can see that Hawaiians have some 12.3% who are unable as compared to only 5.6% of Part-Hawaiians. This is due in part to the differences in age and in the types of chronic conditions these two

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subgroups of Native Hawaiians experience.

In looking at specific conditions, malignant neoplasm is the condition which has the highest percentage of severe limitation for Hawaiians (44.4%) and Part-Hawaiians (19.1%). More Hawaiians are unable to carry on their major activity probably due to their older age as a group, as compared with Part-Hawaiians. For Hawaiians, the next most limiting conditions are visual impairments (35.6%), mental and nervous condition (32.3%), other (21.3%), varicose veins (14.2%), arthritis and rheumatism (13.6%), heart conditions (13.5%), gout (13.5%), and hearing impairments (13.2%) Part-Hawaiians differ in that their next most limiting conditions are mental and nervous conditions (14.6%), visual impairments (12.5%), arthritis and rheumatism (12.4%), diabetes (10.9%), heart conditions (9.8%), and other (8.4%). Although there is considerable overlap in the kinds of conditions causing severe limitation of activity, the major finding is that the percentages of persons with severe limitation is much higher for Hawaiians than for Part-Hawaiian.

Now that it has been shown that a greater proportion of Hawaiians suffer severe limitation than Part-Hawaiians from a similar set of chronic conditions, we will now discuss the opposite end of the limitation spectrum, i.e., "No limitation" for each of the chronic conditions listed in the second part of Table III-11. As mentioned earlier, some 75.7% of the total population suffer "no limitation" of usual activity as a result of chronic conditions they have. Native Hawaiians and Part-Hawaiians have nearly the same percentages who suffer no limitation due to their chronic conditions. Hawaiians by contrast have a lower percentage (63.3%) who suffer no limitation. This means that chronic conditions

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overall create greater or more severe limitation of activity among Hawaiians than for Part-Hawaiians, Native Hawaiians or for the total population.

In looking at specific chronic conditions we can see that some of the most prevalent conditions are also the least limiting (i.e., have the highest percentage of no limitation). For Hawaiians the least limiting conditions are benign and unspecified neoplasms (95.4%), chronic sinusitis (92.1%), hayfever (86.3%), high blood pressure (85.7%), and chronic and allergic skin condition (81.5%). Part-Hawaiians by contrast have the following conditions which are least limiting: hayfever (92.8%), chronic and allergic skin condition (87.2%), asthma (87.1%), goiter (85.3%), hemorroids (82.3%), high blood pressure (82.0%) and bronchitis/emphysema (82.0%).

In summary, Hawaiians have much higher percentages of persons suffering from chronic conditions and reporting severe limitation of activity than do Part-Hawaiians or the general population. The specific conditions which Native Hawaiians, both subgroups, most frequently report as causing severe limitation are heart conditions, visual impairments, arthritis and rheumatism, mental and nervous disorders. In addition, Hawaiians suffer severe limitation from varicose veins and gout and Part-Hawaiians from diabetes. These are the chronic conditions which appear to be most debilitating and which have the greatest negative effects for Native Hawaiians.

In addition to Table III-11 which illustrates the percentages of Native Hawaiians with chronic conditions who have "severe" and "no" limitation of usual activity, it is useful to consider the

concept of causation of limitation. Table III-12 shows the percentages of persons within each ethnic group who claim that a specific chronic condition causes their limitation of activity. This is in contrast to Table III-11 where there may be overlapping conditions responsible for the activity limitation. Table III-12 also provides us with a comparison of different ethnic groups as a way of indicating the differences and similarities of Native Hawaiians with others in the population.

Native Hawaiians in general, and Hawaiians in particular, have the highest percentages of persons reporting chronic conditions as a cause of their limitation of activity. In order to make the comparisons easier, Table III-13 shows the ranking of percentages across each condition. Table III-13 shows which ethnic group has the highest percentage of limitation for each condition. Hawaiians are ranked number one on seven of the twenty chronic conditions and Part-Hawaiians are ranked number one on an additional six, meaning that between the two groups of Native Hawaiians thirteen out of twenty chronic conditions are ranked the highest in terms of the percentages reporting that those conditions are the cause of their activity limitation.

The specific conditions which Hawaiians report as causing their limitations are heart conditions, mental and nervous conditions, visual impairments, hayfever, hemorroids, and gout. The sepcific conditions which Part-Hawaiians report highest as causing their limitations are arthritis and rheumatism, hearing impairments, chronic and allergic skin conditions, chronic sinusitis, stomach ulcer and benign and unspecified neoplasm. Some of this list repeat those reported in Table III-11, i.e., heart conditions, mental and

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nervous conditions, visual impairments, arthritis and rheumatism, hearing impairments, and gout. Diabetes which was also ranked high in Table III-11 is ranked second for Hawaiians and fourth for Part-Hawaiians. Stomach ulcer, benign & unspecified neoplasm were ranked higher in Table III-12 than in Table III-13.

It appears that by looking at the effects of chronic conditions upon the usual activities of Native Hawaiians that the greatest or most severe limitation is caused by heart conditions, mental and nervous condtions, visual impairments, hayfever, hemorroids, gout, arthritis and rheumatism, hearing impairments, chronic and allergic skin conditions, and diabetes. In addition, high blood pressure, malignant neoplasms, impairment of back or spine, asthma and bronchitis/emphysema are also very prevalent (higher than in other groups) even though their effect in terms of limitation of usual activity are not as severe.

The previous discussion has focused upon limitation of usual activity as an indicator of the severity of effects of chronic conditions. Next will be a consideration of a different kind of effect which is not associated with any specific illness conditions, but rather with illness or morbidity in general. This concept is restriction from going to school for school children, restriction from going to work for those who work, and spending time in bed all or most of the day due to illness. Table III-14 facilitates our discussion of these measures of effect. School loss days and work loss days were obtained by asking respondents how many days they stayed home from school or from work during a specific period of time due to illness. These data were used to estimate the total number of days per year, and the data in Table III-14 show the

average number of days per year a person stayed home from school, for children, from work, for workers. Bed days were obtained in a similar manner, with persons asked to indicate how many days they had to stay in bed all or most of the day due to illness during a given period.

Bed days is an indicator of more severe impact than a school loss day or work loss day, since most persons who stay home from school or work due to illness are not confined to bed all or most of the day. Table III-14 illustrates across the different ethnic groups which ones had more school and work loss days and bed days due to illness, thus indicating degree of impact of illness.

In comparing Native Hawaiians with other groups, it appears that Native Hawaiians have the greatest average number of days lost from school and from work due to illness as compared with other groups. Within the Native Hawaiian category, Hawaiians have more work loss days (4.3/year) than Part-Hawaiians (3.2). Conversely, Hawaiians had fewer school loss days per year (2.1) than Part-Hawaiians (2.5). Thus, based upon these two indicators of severity of effects of illness Native Hawaiians appear to suffer more from the effects of illness than do other groups.

In looking at the average number of days spent in bed due to illness, Native Hawaiians as a group are second only to Caucasians. However, Hawaiians, within the Native Hawaiian category, are much higher than any other group with an average of 8.5 bed days per person per year due to illness. This is twice the number of days spent in bed for the population as a whole (4.3 days). Part-Hawaiians exceeded the average by a small margin (4.9 days). From this indicator we might conclude that Hawaiians suffer a

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greater impact from illness conditions than does any other group, since the number of days in bed is the indicator of greatest severity. This is due perhaps to the kinds of illnesses Hawaiians suffer and also due to their overall older population as compared with the other groups.

D. SUMMARY

Native Hawaiians have higher prevalence rates than non-Hawaiians on many chronic conditions. Within the Native Hawaiian group, Hawaiians have the highest rates for heart conditions, diabetes, malignant neoplasms, goiter and varicose veins. Part-Hawaiians have the highest rates on: impairment of back or spine, high blood pressure, hearing impairments, asthma, bronchitis/emphysema, and gout. Hawaiians, being older as a group, experience high rates of morbidity conditions associated with aging compared with Part-Hawaiians, who are generally younger as a group, who experience higher rates of respiratory conditions and impairments. Both categories experience high rates of conditions associated with diet/nutrition.

Native Hawaiian males generally have lower prevalence rates for chronic conditions than do females. For Hawaiians, both genders experience high rates of high blood pressure. Males have higher rates for heart conditons, diabetes, impairment of back or spine and hearing. Females have higher rates on arthritis/rheumatism, and asthma. For Part-Hawaiian males, impairments of back or spine are, high as compared with females who have higher rates on asthma, high blood pressure and hayfever. Thus, males appear to have more impairments and degenerative conditions and females experience more respiratory conditions. Both genders have high rates on dietary

related conditions, such as diabetes and high blood pressure.

Thus, for Native Hawaiians, high blood pressure, heart conditons, hayfever, asthma, impairments of back or spine and hearing, diabetes, bronchitis/emphysema, malignant neoplasms, gout, varicose veins and goiter are the most prevalent chronic conditions.

For acute conditions, by far the most common are upper respiratory conditions. This is also the most common acute conditon for other major ethnic groups in Hawaii. For upper respiratory conditions, Part-Hawaiians experience the highest incidence as compared with Hawaiians and other ethnic groups. Overall, Native Hawaiian rates for acute conditions were intermediate compared with those for other ethnic groups. Female rates are higher than male rates.

Mortality is higher among Native Hawaiians than non-Hawaiians and among Hawaiians than Part-Hawaiians. Even when controlling for age differences among Hawaiians and Part-Hawaiians, the Hawaiians have higher mortality. Life expectancy is about five years less for Native Hawaiians than for the population in general. The causes of death which contribute most to mortality of Native Hawaiians are diseases of the heart, malignant neoplasms, hypertension, cerebrovascular disease, diabetes and motor vehicle accidents.

As a rule, Native Hawaiians experience greater activity limitation and restriction of activity due to illness than non-Hawaiians. Hawaiians experience more severe effects of morbidity than do Part-Hawaiians. Malignant neoplasms, visual impairments, mental and nervous conditions, heart conditions, arthritis and rheumatism, diabetes, hearing impairments, varicose veins and gout are the chronic conditions responsible for the .

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severist level of activity limitation among Native Hawaiians.

Restricted activity days such as school loss or work loss days and days spent in bed are higher for Native Hawaiians than non-Hawaiians. Hawaiians have more work loss and bed days due to illness and Part-Hawaiians have more school loss days due to illness among Native Hawaiians. The effect of morbidity among Native Hawaiians is to prevent or limit their participation in their major daily activities and to restrict their activities by keeping them at home or in bed, thus limiting their productivity and participation in their usual activities.

The kinds of morbid conditions found most commonly among Native Hawaiians and which are responsible for mortality, limitation and restriction of their usual activities might be grouped into four general categories: those which reflect dietary/nutritional problems, those which reflect lifestyle/environmental problems, those which are due to aging, and those which come from accidents or injuries. Hawaiians tend to have problems associated with aging. The Part-Hawaiians, who are younger, have problems with accidents and injuries as well as life style/environmental problems. Native Hawaiians share equally in problems associated with diet and nutrition. Programs for prevention and treatment must consider the underlying factors associated with mortality and morbidity conditions in order to be effective. It is also of importance that sub-groups of Native Hawaiians be identified with respect to those problems of importance to their specific group.

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TABLE III-1,AGE ADJ'D DEATH RATES BY CAUSE, ETHNICITY HAWAII 1980-84

(Rates per 100,000) CAUSE OF DEATH	TOTAL	NATIVE HAW'N	HAW'N	PART-HAW'N	NON-HAW'N
INFLUENZA & PNEUMONIA	19.0	19.3	38.5	14.2	18.9
BRONCHITIS EMPH ASTHMA	5.7	6.9	6.8	5.3	5.5
PEPTIC ULCER	1.8	1.1	0.0	1.4	1.8
CIRRHOSIS OF LIVER	7.2	6.6	6.2	6.3	7.3
NEPHRITIS & NEPHROSIS	4.5	5.4	12.5	3.7	4.3
PREG CHILDBIRTH & PEUR	0.1	0.0	0.0	0.0	0.1
CONGENTIAL ANOMALIES	7.3	7.1	0.0	7.3	7.4
PERINATIAL CONDITIONS	8.3	9.8	0.0	10.0	7.6
ILL DEFINED CONDITIONS	5.0	5.0	6.2	5.1	4.9
OTHER DISEASES	50.4	61.5	110.4	56.2	48.6
ACCIDENTAL DEATHS	28.9	34.3	46.3	30.1	27.8
MOTOR VEHICLE	16.3	21.7	46.3	20.6	15.0
OTHER TRANSPORTATION	1.8	0.6	0.0	0.6	2.1
POISONING	0.4	0.0	0.0	0.0	0.4
FALLS	3.3	3.7	0.0	2.0	3.6
FIRES	0.5	0.0	0.0	0.0	0.5
DROWNING SUBMERSIONS	3.7	4.2	0.0	4.7	3.5
FIREARMS MISSLES	0.2	0.0	0.0	0.0	0.1
ADVERSE EFFECTS	0.0	0.0	0.0	0.0	0.0
OTHER ACCIDENTS	2.7	2.0	0.0	2.2	2.7
SUICIDE	10.7	9.9	13.2	9.9	10.7
HOMICIDE LEGAL INTERV	4.7	6.7	20.0	5.6	4.4
OTHER EXTERNAL CAUSES	4.0	3.0	0.0	3.1	3.9

SOURCE: Vital Statistics, Hawaii State Dept of Health

TABLE III-1, AGE ADJ'D DEATH RATES BY CAUSE, ETHNICITY HAWAII 1980-84

(Rates per 100,000) CAUSE OF DEATH	TOTAL	NATIVE HAW'N	HAW'N	PART-HAW'N	NON-HAW'N
ALL CAUSES	541.2	763.6	1427.3	653.4	511.3
PRESUMPTIVE	0.3	0.0	0.0	0.0	0.3
TUBERCULOSIS	1.0	1.1	0.0	0.0	1.0
SYPHILIS	0.1	0.0	0.0	0.0	0.0
OTHER INFECT & PARA DIS	5.5	9.2	12.5	7.1	5.1
MALIGNANT NEOPLASMS	130.5	185.1	324.2	160.5	123.4
DIGESTIVE ORGANS	44.4	56.3	110.2	47.8	42.9
RESPIRATORY SYSTEM	31.4	50.8	97.5	42.1	28.8
BREAST	8.7	17.3	32.5	16.5	7.7
GENITAL ORGANS	11.7	15.0	25.5	12.9	11.1
URINARY ORGANS	5.0	6.9	6.2	6.6	4.6
LEUKEMIA	24.7	6.9	6.2	30.2	23.3
OTHER	13.5	32.0	45.4	24.1	11.2
DIABETES MELLITUS	228.8	31.3	84.7	296.7	213.0
CIRCULATORY DISEASES	174.1	355.1	688.6	242.0	160.1
HEART DISEASES	2.3	286.9	561.0	3.6	1.8
RHEUMATIC	6.5	4.8	26.2	10.2	5.6
HYPERTENSIVE	119.3	13.6	19.3	165.4	110.2
ISCHEMIC	46.0	193.0	341.5	60.9	42.1
OTHER	2.0	76.7	160.6	2.4	1.7
HYPERTENSION	41.2	3.1	6.2	37.0	40.3
CEREBROVASCULAR	4.5	47.3	89.6	4.1	4.4
ARTERIOSCLEROSIS	7.0	5.6	12.5	9.4	6.4
OTHER CIRCULATORY	0.0	11.0	19.3	0.0	0.0

TABLE III-2, RANKING OF DEATH RATES BY CAUSE, ETHNICITY HAWAII 1980-84

CAUSE OF DEATH	OVER-ALL	NATIVE HAW'N	HAW'N	PART-HAW'N	NON-HAW'N
MALIGNANT NEOPLASMS:					
DIGESTIVE ORGANS	5	4	4	5	4
RESPIRATORY SYSTEM	8	5	5	6	7
LEUKEMIA	5			8	9
OTHER	9	8	9	10	
DIABETES MELLITUS	6	9	7	1	1
HEART DISEASES:					
HYPERTENSIVE	1			2	2
ISCHEMIC	2	1	1	3	5
OTHER	1	2	2		
HYPERTENSION	4			7	6
CEREBROVASCULAR	3	6	6		
INFLUENZA & PNEUMONIA	7		10		10
OTHER DISEASES	4	3	3	4	3
ACCIDENTAL DEATHS	10	7	8	9	8
MOTOR VEHICLE	6	10	8		

SOURCE: Vital Statistics, Hawaii State Dept of Health

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TABLE III-3, RANKING OF DEATH RATES, ETHNICITY & CAUSE HAWAII 1980-84

CAUSE OF DEATH	NATIVE HAW'N	HAW'N	PART-HAW'N	NON-HAW'N
OVERALL RANKINGS	2	1	3	4
MALIGNANT NEOPLASMS	2	1	3	4
DIGESTIVE ORGANS	2	1	3	4
RESPIRATORY SYSTEM	2	1	3	4
LEUKEMIA	3	4	1	2
OTHER	2	1	3	4
DIABETES MELLITUS	4	3	1	2
HEART DISEASES	2	1	3	4
HYPERTENSIVE	4	3	1	2
ISCHEMIC	2	1	3	4
OTHER	2	1	3	4
HYPERTENSION	4	3	2	1
CEREBROVASCULAR	2	1	4	3
INFLUENZA & PNEUMONIA	2	1	4	3
OTHER DISEASES	2	1	3	4
ACCIDENTAL DEATHS	2	1	3	4
MOTOR VEHICLE	2	1	3	4

SOURCE: Vital Statistics, Hawaii State Dept of Health

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TABLE III-4, INCIDENCE/PREVALENCE OF ACUTE CONDITIONS, HAWAII 1980-84

CONDITION (RATES/1000)	CAUC-ASIAN	JAPAN-ESE	NATIVE HAW'N	HAW'N	PART HAW'N	FILIP-INO	CHIN-ESE	OTHER/UNKNWN	TOTAL
ALL ACUTE	2407.6	1567.3	2398.9	1547.8	2438.9	1573.3	1459.0	2457.0	2080.8
INFECT/PARASITIC	1797.7	72.8	120.7	58.4	123.7	91.0	105.8	136.2	122.8
ALL RESPIRATORY	1573.7	1151.0	1777.5	1064.7	1811.0	1217.8	1030.1	1794.6	1486.7
UPPER RESPIRATORY	1230.8	971.8	1495.4	896.9	1523.5	980.6	903.1	1490.7	1221.9
INFLUENZA	292.0	139.4	238.1	135.9	242.9	141.4	102.1	237.7	211.2
OTHER RESPIRATORY	50.9	40.3	44.0	31.9	44.5	95.8	24.9	66.3	53.6
DIGESTIVE	46.8	30.2	41.2	25.3	39.2	27.2	15.3	39.0	36.4
INJURIES	286.8	147.1	190.3	157.7	191.8	86.0	139.1	206.7	192.6
OTHER ACUTE	320.5	166.2	271.9	350.0	273.3	151.2	168.8	280.5	242.4

SOURCE: Health Surveillance Survey, Hawaii State Dept of Health

TABLE III-5, ACUTE CONDITIONS OF HAWAIIANS BY GENDER, HAWAII 1980-84

CONDITION (RATES/1000)	NATIVE HAWAIIAN: TOTAL	MALE	FEMALE	HAWAIIAN: TOTAL	MALE	FEMALE	PART HAWAIIAN: TOTAL	MALE	FEMALE
ALL ACUTE	2398.9	2269.4	2529.8	1547.8	1270.6	1813.4	2438.9	2315.0	2564.4
INFECT/PARASITIC	120.7	99.2	142.4	58.4	81.8	35.9	123.7	100.0	147.6
ALL RESPIRATORY	1777.5	1685.3	1870.7	1064.7	903.9	1218.6	1811.0	1721.0	1902.1
UPPER RESPIRATORY	1495.4	1415.8	1575.9	896.9	752.5	1035.2	1523.5	1446 0	1602.0
INFLUENZA	238.1	219.2	257.2	135.9	86.2	183.6	242.9	225.3	260.7
OTHER RESPIRATORY	44.0	50.3	37.6	31.9	65.2	0.0	44.5	49.6	39.4
DIGESTIVE	41.2	31.6	45.5	25.3	40.9	10.3	39.2	31.2	47.2
INJURIES	190.3	228.6	151.6	157.7	81.5	230.7	191.8	235.3	147.8
OTHER ACUTE	271.9	224.7	319.5	350.0	162.6	317.7	273.3	227.5	319.6

SOURCE: Health Surveillance Survey, Hawaii State Dept of Health

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TABLE III-6, RANKING OF ACUTE CONDITION RATES BY ETHNICITY, HAWAII 1980-84

CONDITION (RATES/1000)	CAUC-ASIAN	JAPAN-ESE	NATIVE HAW'N	HAW'N	PART HAW'N	FILIP-INO	CHIN-ESE	OTHER/UNKNWN	TOTAL
INFECT/PARASITIC	1	5	5	5	5	5	4	5	5
UPPER RESPIRATORY	2	1	1	1	1	1	1	1	1
INFLUENZA	4	4	3	4	3	3	5	3	3
OTHER RESPIRATORY	6	6	6	6	6	4	6	6	6
DIGESTIVE	7	7	7	7	7	7	7	7	7
INJURIES	5	3	4	3	4	6	3	4	4
OTHER ACUTE	3	2	2	2	2	2	2	2	2

SOURCE: Health Surveillance Survey, Hawaii State Dept of Health

TABLE III-7, RANKING OF ETHNIC GROUPS BY ACUTE CONDITIONS, HAWAII 1980-84

CONDITION (RATES/1000)	CAUC-ASIAN	JAPAN-ESE	NATIVE HAW'N	HAW'N	PART HAW'N	FILIP-INO	CHIN-ESE	OTHER/UNKNWN
ALL ACUTE	3	6	4	8	2	5	7	1
INFECT/PARASITIC	1	7	4	8	3	6	5	2
ALL RESPIRATORY	4	6	3	7	1	5	8	2
UPPER RESPIRATORY	4	6	2	8	1	5	7	3
INFLUENZA	1	6	3	7	2	5	8	4
OTHER RESPIRATORY	3	6	5	7	4	1	8	2
DIGESTIVE	1	5	2	7	3	6	8	4
INJURIES	1	6	4	5	3	8	7	2
OTHER ACUTE	2	7	5	1	4	8	6	3

SOURCE: Health Surveillance Survey, Hawaii State Dept of Health

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TABLE III-8, COMPARISON OF UNADJUSTED AND AGE-ADJUSTED PREVALENCE OF CHRONIC CONDITINS AMONG HAWAIIAN GROUPS, HAWAII 1980-1984

(RATES/1000) CONDITION		NATIVE HAWAIIAN: TOTAL	MALE	FEMALE	HAWAIIAN: TOTAL	MALE	FEMALE	PART HAWAIIAN: TOTAL	MALE
ALL COND	U	523.4	509.7	537.2	795.0	781.5	808.0	510.7	497.3
	A	659.2	645.6	672.3	575.6	576.8	573.3	665.6	649.2
HEART	U	19.6	20.7	18.6	71.8	75.2	68.6	17.2	18.2
	A	30.6	33.6	27.8	49.4	55.7	41.7	29.0	32.1
B & S IMP	U	38.7	44.6	32.7	50.0	63.0	37.6	38.1	43.7
	A	48.5	58.0	39.1	41.8	50.2	34.7	49.5	58.9
HBP	U	54.8	53.3	56.3	120.9	117.3	124.3	51.7	50.4
	A	85.5	82.7	87.6	82.1	83.4	79.0	87.6	84.1
ARTHRITIS	U	16.3	9.6	23.2	50.5	22.1	77.7	14.7	9.0
	A	27.5	17.1	37.4	28.8	12.6	42.4	27.2	17.7
HEARING	U	21.8	27.7	15.9	44.1	61.1	27.8	20.8	26.1
	A	28.5	36.5	20.8	25.9	38.2	13.7	27.9	35.2
ASTHMA	U	57.2	51.6	62.8	41.6	11.9	70.0	57.9	53.4
	A	53.7	44.0	63.2	42.6	8.2	80.5	54.0	45.0
DIABETES	U	19.4	18.3	20.4	69.2	71.1	67.4	17.0	15.9
	A	31.6	30.7	32.5	44.2	47.7	40.4	30.4	29.1
ALLER SKIN	U	24.8	22.7	26.8	13.1	22.9	3.7	25.3	22.7
	A	25.4	23.7	27.2	10.5	19.6	1.7	26.1	23.7
SINUSITIS	U	15.7	13.5	17.9	5.6	6.6	4.7	16.2	13.8
	A	17.5	15.1	20.0	4.5	4.9	4.7	18.4	15.5
HAYFEVER	U	41.2	34.5	47.7	17.5	16.5	18.4	42.2	35.3
	A	42.1	33.0	50.9	15.8	18.8	13.2	43.7	33.9
BRONCHITIS	U	16.9	16.2	17.6	18.7	17.0	20.3	16.8	16.2
	A	17.7	17.2	18.5	15.0	11.2	18.9	17.9	17.1

SOURCE: Excerpts from Appendix Table 4, Health Surveillance Program
NOTE: U = Unadjusted rates, A = Age-adjusted rates

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TABLE III-9,RANK OF CHRONIC CONDITION AGE-ADJUSTED RATES BY ETHNICITY
HAWAII 1980-1984

CHRONIC CONDITION	CAUC-ASIAN	JAPAN-ESE	NATIVE HAW'N	HAW'N	PART HAW'N	FILIP-INO	CHIN-ESE	OTHER/ UNKNWN	TOTAL
HEART COND	9	10	6	2	6	9	8	10	9
IMP BCK/SPINE	3	3	3	5	3	3	5	2	3
HBP W/O HEART	2	1	1	1	1	1	1	1	1
ARTHRITIS	4	7	8	6	8	4	6	6	6
HEARING IMP	6	4	7	7	7	7	7	8	5
ASTHMA	8	6	2	4	2	2	4	4	4
DIABETES	13	8	5	3	5	6	9	9	10
MENTAL & NERV	11	15	15	14	15	12	14	11	13
VISUAL IMP	14	12	13	11	14	13	13	14	14
MALIGNANT NEO	15	19	18	15	18	18	17	19	18
ALLERG SKIN	7	5	9	13	9	5	3	5	7
CHRONIC SINUS	5	9	11	18	10	10	10	7	8
HAYFEVER	1	2	4	8	4	4	2	3	2
STOMACH ULCER	17	17	17	19	17	11	16	16	17
BRONCHITIS	12	14	10	9	11	14	15	13	12
BENIGN NEO	18	18	20	16	20	15	18	18	19
HEMORROIDS	10	11	14	16	13	13	11	12	11
GOITER	20	20	19	17	19	17	20	20	20
VARICOSE VEIN	16	16	16	12	16	16	19	17	16
GOUT	19	13	12	10	12	8	12	15	15

SOURCE: Health Surveillance Survey, Hawaii State Dept of Health

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TABLE III-10, RANKING OF ETHNICITY BY AGE-ADJUSTED CHRONIC CONDITIONS
HAWAII 1980-1984

CHRONIC COND	CAUC-ASIAN	JAPAN-ESE	NATIVE HAW'N	HAW'N	PART HAW'N	FILIP-INO	CHIN-ESE	OTHER/UNKN	OVERALL MAN RANK
ALL CONDITIONS	1	6	4	5	3	8	7	2	
HEART COND	4	7	2	1	3	8	6	5	HIGH
IMP BCK/SPINE	1	5	4	6	3	8	7	2	MEDIUM
RESP W/O HEART	8	4	2	3	1	5	7	6	HIGH
ARTHRITIS	1	7	4	3	5	8	6	2	MEDIUM
HEARING IMP	1	2	3	5	4	8	7	6	MEDIUM
ASTHMA	6	8	2	3	1	7	5	4	HIGH
DIABETES	7	5	2	1	3	6	6	4	HIGH
MENTAL & NERV	1	7	4	5	3	6	8	2	MEDIUM
VISUAL IMP	2	6	4	5	3	8	7	1	MEDIUM
MALIGNANT NEO	1	6	3	2	5	7	4	3	HI/MED
ALLERG SKIN	1	4	5	8	6	7	2	3	LOW
CHRONIC SINUS	1	3	5	7	4	8	6	2	LOW
HAYFEVER	1	3	6	8	5	7	2	4	LOW
STOMACH ULCER	3	7	5	8	4	2	6	1	LOW
BRONCHITIS	1	6	3	5	2	8	7	4	HI/MED
BENIGN NEO	1	4	6	2	7	8	5	3	MED/LOW
HEMORROIDS	1	5	6	8	4	7	3	2	LOW
GOITER	3	4	5	1	6	8	7	2	MEDIUM
VARICOSE VEIN	1	6	4	2	5	8	7	3	HI/MED
GOUT	8	7	1	4	2	3	5	6	HIGH

SOURCE. Health Surveillance Survey, Hawaii State Dept of Health

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TABLE III-11, ACTIVITY LIMITATION BY COND & ETHNICITY,HAWAII 1980-84

PERCENTAGE UNABLE TO CARRY ON MAJOR ACTIVITY DUE TO CONDITION

CHRONIC CONDITION	TOTAL POPULATION	NATIVE HAW'N	HAW'N	PART HAW'N
ALL CONDITIONS	6.2	6.1	12.3	5.6
HEART CONDITIONS	11.6	10.4	13.5	9.8
IMPAIR OF BACK OR SPINE	4.4	4.9	8.5	4.5
HRT W/O HEART INVOLVMENT	3.5	4.5	0.9	4.9
ARTHRITIS & RHEUMATISM	8.3	12.6	13.6	12.4
HEARING IMPAIRMENTS	6.9	5.4	13.2	4.6
ASTHMA	1.6	1.7	4.9	1.7
DIABETES	7.9	10.6	9.1	10.9
MENTAL & NERV CONDITIONS	11.2	15.6	32.3	14.6
VISUAL IMPAIRMENTS	13.3	14.7	35.6	12.5
MALIGNANT NEOPLASMS	17.1	23.2	44.4	19.1
CHRON & ALLERG SKIN COND	2.2	1.0	0.0	1.0
CHRONIC SINUSITIS	1.4	1.9	7.9	1.8
HAYFEVER W/O ASTHMA	0.9	0.6	0.0	0.6
STOMACH ULCER	5.8	2.2	0.0	2.3
BRONCHITIS, EMPHYSEMA	6.7	4.8	5.9	4.7
BENIGN & UNSPEC NEOPLASM	5.1	5.1	4.6	5.2
HEMORROIDS	2.5	0.9	0.0	1.0
THYROID GOITER	3.7	2.2	0.0	2.4
VARICOSE VEINS	2.9	4.2	14.2	2.5
GOUT	4.7	5.2	13.5	4.2
OTHER	9.5	9.1	21.3	8.4

SOURCE: Health Surveillance Survey, Hawaii State Dept of Health (continued)

(continued)

TABLE III-11, ACTIVITY LIMITATION BY COND & ETHNICITY,HAWAII 1980-84

PERCENTAGE NOT LIMITED IN ACTIVITY DUE TO CONDITION

CHRONIC CONDITION	TOTAL POPULATION	NATIVE HAW'N	HAW'N	PART HAW'N
ALL CONDITIONS	75.7	75.5	63.3	76.4
HEART CONDITIONS	54.9	48.8	38.1	50.8
IMPAIR OF BACK OR SPINE	73.0	72.7	66.1	73.1
HBP W/O HEART INVOLVMENT	83.6	82.4	85.7	82.0
ARTHRITIS & RHEUMATISM	66.0	61.0	63.6	60.6
HEARING IMPAIRMENTS	74.0	75.1	67.8	75.9
ASTHMA	86.6	86.7	76.5	87.1
DIABETES	73.5	67.2	73.7	65.9
MENTAL & NERV CONDITIONS	65.2	60.1	50.5	60.6
VISUAL IMPAIRMENTS	57.2	58.5	42.7	60.2
MALIGNANT NEOPLASMS	58.4	49.2	36.5	51.7
CHRON & ALLERG SKIN COND	87.8	87.1	81.5	87.2
CHRONIC SINUSITIS	89.2	91.7	92.1	91.7
HAYFEVER W/O ASTHMA	92.4	92.7	86.3	92.8
STOMACH ULCER	77.8	80.9	75.1	81.2
BRONCHITIS, EMPHYSEMA	76.7	81.5	72.1	82.0
BENIGN & UNSPEC NEOPLASM	80.8	80.9	95.4	79.6
HEMORROIDS	85.3	81.0	44.3	82.3
THYROID GOITER	84.2	81.8	52.7	85.3
VARICOSE VEINS	78.7	77.5	77.8	77.5
GOUT	78.6	75.7	58.3	77.9
OTHER	67.9	67.6	47.7	68.8

SOURCE: Health Surveillance Survey, Hawaii State Dept of Health

TABLE III-12, PERCENT OF CONDITIONS CAUSING LIMITATION OF ACTIVITY, BY ETH, HAWAII 1980-4

CHRONIC CONDITION	TOTAL	CAUC -ASIAN	JAPAN -ESE	NATIVE HAW'N	HAW'N	PART HAW'N	FILI -PINO	CHIN -ESE	OTHER & UNKNWN
ALL CONDITIONS	45.8	42.7	42.7	50.6	51.3	50.5	47.7	42.9	45.2
HEART CONDITIONS	70.9	69.3	69.3	75.4	83.2	73.5	75.7	71.0	63.2
IMPAIR OF BACK OR SPINE	76.9	77.8	77.8	74.9	64.1	75.7	79.6	65.3	80.1
HBP W/O HEART INVOLVMENT	21.9	19.1	19.1	23.2	27.3	22.8	20.1	33.7	21.5
ARTHRITIS & RHEUMATISM	52.2	51.0	51.0	63.8	57.7	64.6	51.0	43.6	44.6
HEARING IMPAIRMENTS	15.5	13.4	13.4	25.8	0.0	29.6	21.0	3.6	11.5
ASTHMA	47.2	50.2	50.2	51.4	43.7	51.8	54.5	46.0	35.4
DIABETES	26.0	29.9	29.9	28.1	29.5	27.9	33.9	13.0	27.3
MENTAL & NERV CONDITIONS	49.7	44.8	44.8	65.9	69.6	65.5	35.6	42.3	48.4
VISUAL IMPAIRMENTS	46.6	45.2	45.2	49.2	82.6	44.4	41.4	49.5	42.3
MALIGNANT NEOPLASMS	54.9	43.0	43.0	50.6	30.8	55.6	82.8	68.5	69.2
CHRON & ALLERG SKIN COND	16.6	12.6	12.6	22.9	0.0	24.4	10.6	9.4	17.9
CHRONIC SINUSITIS	13.3	12.1	12.1	23.4	0.0	25.0	31.3	0.0	13.7
HAYFEVER W/O ASTHMA	17.3	16.0	16.0	13.6	100.0	11.1	8.3	13.0	28.9
STOMACH ULCER	24.7	18.6	18.6	43.7	28.9	45.8	27.1	0.0	20.4
BRONCHITIS, EMPHYSEMA	37.2	40.3	40.3	38.0	6.0	41.1	30.5	56.1	26.8
BENIGN & UNSPEC NEOPLASM	27.7	21.5	21.5	51.2	0.0	55.9	24.0	0.0	21.4
HEMORROIDS	3.8	1.9	1.9	7.3	23.5	5.7	4.2	21.3	6.6
THYROID GOITER	14.0	4.5	4.5	11.9	0.0	16.4	33.9	100.0	25.6
VARICOSE VEINS	16.8	21.4	21.4	12.7	6.8	14.1	11.8	0.0	25.2
GOUT	31.7	38.8	38.8	39.7	67.8	33.7	38.5	11.1	26.4
OTHER	54.6	48.3	48.3	59.5	60.6	59.4	55.9	51.1	55.1

SOURCE: Health Surveillance Survey, Hawaii State Dept of Health

TABLE III-13, RANKING OF PERCENTAGE CAUSING LIMITATION OF ACT, BY ETH, HAWAII 1980-4

CHRONIC CONDITION	CAUC -ASIAN	JAPAN -ESE	NATIVE HAW'N	HAW'N	PART HAW'N	FILI -PINO	CHIN -ESE	OTHER & UNKWN
ALL CONDITIONS	7	7	2	1	3	4	6	5
HEART CONDITIONS	6	6	3	1	4	2	5	7
IMPAIR OF BACK OR SPINE	3	3	5	7	4	2	6	1
HBP W/O HEART INVOLVMENT	7	7	3	2	4	6	1	5
ARTHRITIS & RHEUMATISM	4	4	2	3	1	4	6	5
HEARING IMPAIRMENTS	4	4	2	7	1	3	6	5
ASTHMA	4	4	3	6	2	1	5	7
DIABETES	1	1	3	2	4	6	7	5
MENTAL & NERV CONDITIONS	5	5	2	1	3	7	6	4
VISUAL IMPAIRMENTS	4	4	3	1	5	7	2	6
MALIGNANT NEOPLASMS	6	6	5	7	4	1	2	3
CHRON & ALLERG SKIN COND	4	4	2	7	1	5	6	3
CHRONIC SINUSITIS	5	5	3	6	1	2	6	4
HAYFEVER W/O ASTHMA	3	3	4	1	6	7	5	2
STOMACH ULCER	5	5	2	3	1	4	7	6
BRONCHITIS, EMPHYSEMA	3	3	4	7	2	5	1	6
BENIGN & UNSPEC NEOPLASM	4	4	2	6	1	3	6	5
HEMORROIDS	7	7	3	1	5	6	2	4
THYROID GOITER	6	6	5	7	4	2	1	3
VARICOSE VEINS	2	2	4	6	3	5	7	1
GOUT	3	3	2	1	5	4	7	6
OTHER	7	7	2	1	3	4	6	5

SOURCE: Health Surveillance Survey, Hawaii State Dept of Health

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TABLE III-14, SCHOOL LOSS, WORK LOSS AND BED DAYS DUE TO ILLNESS BY ETH, HAWAII 1980-4

TYPE OF DAYS LOST (Days per person per Yr)	CAUC-ASIAN	JAPAN-ESE	NATIVE HAW'N	HAW'N	PART HAW'N	FILIP-INO	CHIN-ESE	OTHER/ UNKNWN	TOTAL
SCHOOL LOSS DAYS(UND 17)	1.9	1.6	2.5	2.1	2.5	1.5	2.0	1.9	2.0
WORK LOSS DAYS(AGE 17-64	3.2	2.5	3.3	4.3	3.2	2.8	1.7	2.6	2.8
BED DAYS(ALL AGES)	5.6	3.3	5.0	8.5	4.9	3.6	2.2	4.2	4.3

SOURCE: Health Surveillance Survey, Hawaii State Dept of Health

Prepared Statement By

Ormond W. Hammond, Ph.D.
Kamehameha Schools/Bernice Pauahi Bishop Estate
Honolulu, Hawai'i

May 7, 1986

Good afternoon Chairman Andrews and members of the committee.

My name is Ormond Hammond. I am Director of Program Evaluation and Planning at the Kamehameha Schools/Bishop Estate, an educational institution in Honolulu, established in 1887 for the purpose of educating children of Native Hawaiian descent. I also served as a member of the Strategic Plan Task Force of the Native Hawaiian Health Needs Study.

The purpose of my testimony is to review the recommendations of this, the most comprehensive study to date of Native Hawaiian health needs, and, in so doing, offer support for Senate Bill 2243.

The Kamehameha Schools/Bishop Estate has had a long interest in the health needs of Native Hawaiians, having conducted an earlier study of the educational needs of Native Hawaiians which brought some of these health concerns to light. This earlier study, called the Native Hawaiian Educational Assessment Project (1983), pointed out that Native Hawaiians suffer from multiple physical health problems, including high rates of heart disease and certain forms of cancer, and from mental health problems, including depression, alienation, and other forms of stress related to loss of native culture. In testimony about the educational study before this and other congressional committees, Kamehameha Schools/Bishop Estate representatives have emphasized that health problems can pose a formidable barrier to educational achievement as well as social progress for Native Hawaiians.

What is the background of the Native Hawaiian Health Study?

In FY 1984 both the Senate Select Committee on Indian Affairs and the Senate Appropriations Committee, in separate legislation, called for a comprehensive study of the health needs of Native Hawaiians. Alu Like, Inc., a non-profit community organization assisting Native Hawaiians

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towards economic and social self-sufficiency, after learning of the need for such a study, convened a group of interested researchers and others in Hawaii which became the Native Hawaiian Health Research Consortium. This group, in conjunction with the Department of Health and Human Services, Region IX, conducted a comprehensive review of the health care needs of Native Hawaiians. The Consortium organized the project around five task forces:

1. Historical/Cultural Task Force;
2. Mental Health Task Force;
3. Medical Task Force;
4. Nutrition/Dental Task Force; and
5. Strategic Health Plan Task Force.

What were the major findings of the study?

Each Task Force report contains its own set of findings and recommendations. The Strategic Plan Task Force Report pulls these together in one place and synthesizes the recommendations into a set of six priority program components. Following are some of the major findings:

Cultural/Historical Task Force

1. Ka po'e Hawai'i (Native Hawaiians) were generally healthy people before contact with outside civilizations. They had adapted successfully over some 1,500 years to an island ecosystem. They had a coherent social order and cosmology.

2. They had holistic spiritual values which underlay basically sound health practices.

3. Western contact began a process of deterioration of Hawaiian culture which included health concepts and practices. The native population itself was decimated by diseases for which no resistance had been built.

4. Native Hawaiian culture did not die out, however. It has survived in certain forms and is undergoing a revitalization today.

5. Culture remains important for modern Hawaiians and should be an integral part of any plans for bettering health status.

Mental Health Task Force

1. There are important differences between Western and Native Hawaiian mental health concepts which lead to errors of interpretation and diagnosis.

2. Native Hawaiians have high rates for certain mental health problems including suicide, alcohol and drug abuse, crime, child abuse, school adjustment problems, and certain mental illnesses.

3. Native Hawaiians generally do not utilize existing mental health services because of cultural barriers. Many prefer the personal involvement of traditional healers.

Medical Task Force

1. Native Hawaiians experience disproportionately higher rates of several common chronic illnesses, including heart conditions, hypertension, asthma, diabetes, gout, bronchitis/emphysema, and back problems.

2. Native Hawaiians have higher infant mortality rates than other major ethnic groups, including higher rates of immaturity and incidences of sudden infant death syndrome, and higher rates of congential anomalies.

3. Native Hawaiians suffer from higher rates of cancers of the stomach, lung, and female breast and cervix. In addition,

a. Native Hawaiians tend to be diagnosed at a later stage of cancer;
b. They have poorer survival rates when diagnosed at the same stage of disease;
c. They are not familiar with the risk factors associated with cancer, the symptoms, and methods of early detection; and
d. They underutilize screening programs.

4. Native Hawaiians tend to be underinsured as they are disproportionately among the unemployed and not-in-labor-force groups.

Nutrition/Dental Task Force

1. Native Hawaiian women receive poor care and health education during pregnancy.

2. There is a higher rate of high risk pregnancies, including teenage and illegitimate pregnancies among Native hawaiian young women.

3. The diet of many Native Hawaiians is thought to be inadequate Native Hawaiian preschoolers have been found to have diets deficient in calcium, riboflavin, and vitamins A and C. School age Native Hawaiian children have higher consumption of fats and calories than others and have been found to have higher rates of obesity.

4. Certain dietary and lifestyle factors have been identified as creating particularly high risk for coronary heart disease among Native Hawaiians. These include cigarette smoking, high blood cholesterol, linoleic acid (negatively related), saturated fats, stress, and greater body surface area.

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5. Native Hawaiians have generally poor dental health as measured by caries attack rates, DMF (decayed, missing, and filled teeth), peridontal index, and dental hygiene scores.

In sum, Native Hawaiians have been found to have the poorest overall health status of any of the major ethnic groups in the State of Hawaii. Their life expectancy has been found to be from five to ten years shorter than the average for all groups.

What are the recommendations of the Study? The priorities?

In the Strategic Plan Task Force Report, all of the very specific recommendations from each of the other reports are presented along with suggested Target Agencies, Potential Resources, and Lead Agencies. A total of 74 recommendations are given. Many of these involve similar kinds of approaches. A coordinated system with some six components is suggested. These six components subsume most of the specific recommendations, and thus are the priorities in terms of developing initiatives.

I. Health Research and Surveillance Component

Throughout the health study, the need for more research and for better surveillance data was emphasized. A coordinated effort to improve the data and focus on questions about certain aspects of health among Native Hawaiians is needed. Further, routine surveillance needs to be improved so that interventions can be effectively evaluated. There are several provisions in S. 2243 which would permit the development of just such needed research and surveillance efforts. Specifically, Section 3 (a.1.A, B, and C) calls for the collection of data related to the prevention of disease, medical and health-related research, and mental health research. In Section 6 (a.1.J) provision is made for health surveillance programs to identify any disparity between the health needs of Native Hawaiians that are not being met and the resources available to meet such needs.

II. Traditional Native Hawaiian Health Component

All of the Task Forces emphasized the need to have traditional values, practices, and healers at the forefront of efforts to improve Hawaiian health. The provisions of S. 2243 would permit the development of programs which fully integrate traditional Hawaiian values with needed intervention. This is done through cooperative efforts by Native Hawaiian organizations, each of which has developed effective strategies for incorporating Hawaiian culture, values, beliefs, and human resources into its programs.

III. Primary Health Care Component

The provision of appropriate and responsive health care where needed is the priority here. The model suggested in the report is the Community Health Center (Sec. 330, PHS Act) with community outreach capacity. This recommendation is exactly what is contained in S. 2243, Section 4. This will permit Native Hawaiian communities to develop responsive and community-based health services.

IV. Health Promotion Component

Perhaps the most pervasive theme throughout the study was the need for preventive and educational efforts. Seen as being important causal factors of poor overall health status among Native Hawaiians were lack of knowledge of good health habits, lack of understanding of risk indicators, and the need for culturally appropriate habit and lifestyle change programs. This component reflects the priority placed upon educational and preventive programs. S. 2243 again addresses this priority recommendation throughout Section 3.

V. Professional Health Training Component

The need for this component is clear. Native Hawaiians are seriously underrepresented in all health professions. In Section 5 of S. 2243 this need is directly addressed through the Health Service Scholarship Program. This section is of particular interest to the Kamehameha Schools/Bishop Estate, which conducts a scholarship program for Native Hawaiian students pursuing post-secondary education. We have found that the availability of this assistance has had an effect on reducing the underrepresentation of Native Hawaiians at the University of Hawaii. We feel strongly that the Health Service Scholarship Program in S. 2243 can make a significant impact on increasing the numbers of Native Hawaiian health care professionals.

VI. Health Planning and Monitoring Component

The health study emphasized the need to coordinate and oversee efforts on behalf of Native Hawaiian health improvement. It should involve the State Department of Health as well as other major agencies and institutions impacting upon Native Hawaiian health. The role could be played by an existing Native Hawaiian organization or by the Governor's Advisory Panel on Native Hawaiian Programs. This latter group was constituted by the Governor of the State of Hawaii to advise him on the administration of other federal programs for Native Hawaiians such as the Carl D. Perkins Vocational Education Act of 1984 and the Library Service and Construction Act. By providing management development grants for Native Hawaiian organizations, one objective of which is to provide for health planning, S. 2243 (Section 3[b][1]) will enable this recommendation to become reality.

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In the Report, the interrelatedness of the recommended components was compared to the shared functions within a Hawaiian outrigger canoe as illustrated in Figure 1.

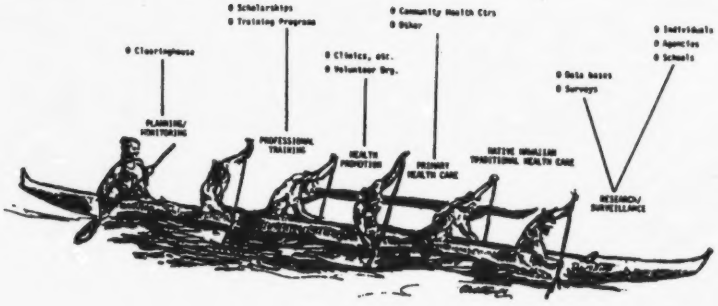
This concept extends also to the need for cooperation at all levels: community, private agencies, State, and Federal. Only through coordinated efforts will all our children be able to reach their highest potential.

Chairman Andrews, I would like to thank you and the other members of your committee for the opportunity to testify in favor of S. 2243. I want to assure you that the Kamehameha Schools/Bishop Estate stands ready to fully participate, along with our sister agencies at the state and local level, in all efforts for the benefit of Native Hawaiians. My colleagues and I remain convinced that, through these kinds of joint efforts, the day will come, in the not-too-distant future, when the history of Native Hawaiians will be considered a success story.

I will be happy to answer any questions you may have.

Figure 1

Components of a Native Hawaiian
Health Care System



This study's proposed model health care system for Native Hawaiians is similar to an efficiently-functioning canoe crew. The speed with which progress is made is determined by the first paddler who sets the pace for the rest of the crew. The second paddler maintains control and calls out the changes in stroke. He also guides the first paddler and tells him to speed up or to slow down. Paddlers three, four, and five are generally the "heavy weights" in the canoe and provide the power for movement. These folks are especially important if long distances are being traversed. The sixth paddler is the steersman and sets the course of the canoe. He is continually reading the waves and currents and gaging these against the strength of his crew.

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Prepared Statement Of

Noa Emmett Aluli, M.D.

Mr. Chairman, Senator Daniel Inouye, Members of the Select Committee on Indian Affairs, and Staff:

Aloha.

I am Noa Emmett Aluli. I am a physician in family practice, on Moloka'i. I'm a graduate in the first class of the University of Hawai'i School of Medicine, in 1975. I have done my residency training in the hospitals of Honolulu. I am a native Hawai'ian, according to Federal definitions (including that contained in the 1920 Hawai'ian Homes Commissions Act), and I am a practitioner of Hawai'ian customs and traditions. I am the president of Na Pu'uwai, a Moloka'i nonprofit organization dedicated to the betterment of the health conditions of the native Hawai'ian. I am a member of an Islands-wide consortium, or "hui", of native Hawai'ian health professionals seeking to serve and represent the native Hawai'ian health professionals: E Ola Mau, the name that the Historical and Cultural Task Force of the Hawai'ian

Health Needs Study has chosen to name itself. I am an organizer and spokesperson for many native Hawai'ian communities on issues pertaining to economic development, historic site preservation, access to traditional resources, and perpetuation of cultural beliefs and practices on all islands including Kaho'olawe, Moloka'i, Hawai'i and Maui.

I support Senate Bill 2243 to improve the health status of native Hawai'ians because of services necessary on the basis of findings described in the bill, and because I am directly involved in primary care medicine in the native Hawai'ian communities on all our islands, as I have provided services in other locales besides Moloka'i including Kaua'i, Lana'i, Maui and Hawai'i. I do, however, have some particular concerns with this bill which I would like to raise at this time.

We are a Pacific Island people. We have no other place but to live and die in Hawai'i. The land is our religion. The rain, the water, the volcano, the native shrubs and trees with their blossoms, are our gods; the native birds, the turtle, and the shark are our ancestors.

Native Hawai'ians have a holistic perception of wellness, health, and life. We cannot be separated from the land, the elements of Hawai'i. As we have lost and continue to lose our source, our connection to the spirits of the land, our gods and our ancestors, we fall sick, confused, alienated and diseased; we suffer pain of dying before our natural time.

Reviving us, repairing us, improving our health status equal

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to that of the general public of Hawai'i and that of the U.S. Mainland will be next to impossible without providing us a solid foundation from which we can improve this generation and the next to follow.

On Moloka'i, Na Pu'uwai, a native Hawai'ian organization, has sponsored a cardiovascular disease risk factor survey of 69% of all individuals ages 20 to 59 living on Hawai'ian Homes Lands. The Moloka'i Heart Study, Phase I, was completed in 1985 and will be presented at the 1986 National Heart, Lung and Blood Institute's Forum on Cardiovascular Disease Risk Factors in Minorities.

Preliminary data on these individuals reveal that 38% were smokers, ranging from 40% in those 20 to 39 years old to 35% in those 40 to 59 years old. The percent with hypertension was 14% of those 20 to 39 and 36% in those 50 to 59. There was glucose spillage in the urine, or a history of diabetes in less than 1% of those 20 to 39 and in 8% of those 40 to 59. In another 8% of those 20 to 39 and 13% of those 40 to 59, the alpha-1-C hemoglobin was elevated to a level indicating the high probability of glucose intolerance. The majority of the known diabetics exhibited moderate or severe glycosuria and elevated glycol-hemoglobin levels. There was increased levels of serum cholesterol in 49% of all participants. Data on serum triglycerides are pending. From this, it would appear that this group of Hawai'ians, (50% or more blood quantum), has high levels of major risk factors for cardiovascular disease. (c.f.

Addendum.)

This data clearly shows that the programs authorized by the proposed legislation is required to raise the status of native Hawai'ian health to acceptable levels. The as yet unreported data being generated by Phase II of the Moloka'i Heart Study, outside the Hawai'ian Homes Lands community, will substantiate that the status of health throughout all native Hawai'ian communities requires that the programs should be authorized by this bill.

It is our experience on Moloka'i and in other predominantly native Hawai'ian communities that a native Hawai'ian organization, composed of majority native Hawai'ian membership and staff have higher success rates in planning, in facilitating, in carrying out studies and surveys, in follow-up program for referral and primary care and in impacting change of appropriate health educational patterns because of the cultural sensitivity and trust that we native Hawai'ians have developed within our own communities.

We on Moloka'i then differ with the definition proposed in this bill which defines the term "native Hawai'ian organization". [§2(4)]. A native Hawai'ian organization should be predominately composed of native Hawai'ians. §2(4)(B) defines a "native Hawai'ian organization" as "one recognized by the governor of the State of Hawai'i for purposes of planning, conducting, or administering programs (or portions of programs) authorized under this Act." We wish to keep of State politics

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out of the improvement of the health status of native Hawai'ians as we have known for so long that State policies and programs have not affected any substantial change in our conditions.

E Ola Mau, a permanent Hawai'ian health organization, is dedicated to encourage, facilitate, consult on, monitor and evaluate Hawai'ian health programs. We would want assurances that whatever native Hawai'ian organizations that the secretary will enter into agreement with are representative of native Hawai'ians, are representative of native Hawai'ian health professionals, and are representative of the native Hawai'ian community needs. We recommend that the Secretary consult with the native Hawai'ian health professionals and with native Hawai'ian programs presently in operation prior to establishing health promotion and disease prevention programs or health centers, or before entering into agreements in connection with native Hawai'ian health programs.

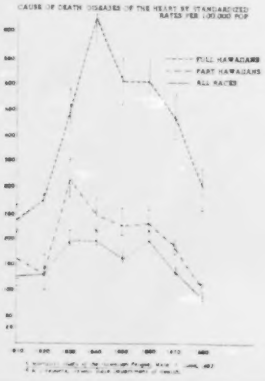
Mr. Chairman, I thank you for the opportunity to present this testimony. I would be pleased to offer any answers to questions you or your staff might have.

Mahalo and aloha.

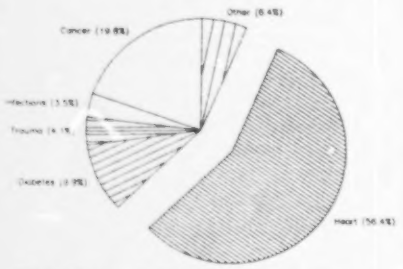
Moloka'i, the last Hawaiian Island save Ni'ihau, has been chosen as the site of a heart study because of the large concentration of Hawaiians and because of the love that her people have for the land, culture, health and welfare of the Island.

Historically: In the two-hundred years since the arrival of Captain Cook the Hawaiian population has been overwhelmed by diseases introduced by continental people. With the modernization of medicine, and with the passage of time, the Hawaiian people have been able to resist the worst of the diseases which once killed them: syphilis, gonorrhea, dysentery, influenza, and Hansen's disease (leprosy). Since 1900 pneumonia, infective and parasitic diseases, and tuberculosis have also been controlled.

Mortality Studies: Statistics of causes of death in Hawai'i from 1910 to 1980, have shown that Hawaiians now have a much higher death rate due to heart disease, hypertension, cancer, and diabetes. In 1984, heart and blood vessel diseases were the most frequent causes of "excess" deaths among Hawaiians.



EXCESS DEATHS PER YEAR IN HAWAIIANS
AGE 45 to 69 YEARS BY CAUSE OF DEATH
("Analysis of Mortality and Morbidity of Native Hawaiians and Pacific Islanders" C.S. Chang, 1983 UH School of Public Health)



Heart Disease: In 1980 heart disease killed three times more full-blooded Hawaiians than all other races. Part-Hawaiians also died of heart disease more often than non-Hawaiians.

Heart disease is a major problem of all people in the U.S. There are certain health conditions which increase the risks of dying of a "heart attack" or a "stroke".

Some of these are high blood pressure, high blood cholesterol, diabetes family history, increased salt intake, obesity, lack of exercise, smoking and stress.

No definitive studies have ever been done of these risk factors as they relate to the Hawaiian people.

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The MOLOKA'I HEART STUDY - NA PU'UWAI

CARDIOVASCULAR RISK FACTOR LEVELS IN ETHNIC HAWAIIANS

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Prepared for presentation at the 1986 Forum on Cardiovascular Disease Risk Factors in Minority Populations [sponsered by the National Heart Lung and Blood Institute and the National High Blood Pressure Education Program], Bethesda, Maryland, June 5-7, 1986

In the first years of contact with western man the native Hawaiian population was devastated by epidemics of infectious diseases from which they had no immunity. Today the life expectancy of native Hawaiians remains the lowest of all the major ethnic groups in Hawaii (Figure One). This is largely due to a new set of diseases for which Hawaiians seem to have a greater propensity than later arrivals to the island chain. Vital statistics data indicate pure Hawaiians have over two times the death rate from cardiovascular disease (CVD) as the rest of Hawaii's population. If one compares the number of deaths in Hawaiians to that in Caucasians in Hawaii, there are proportionately more Hawaiians dying each year in all age groups. The proportion of deaths in Hawaiians which is over and above that occurring in Caucasians can be thought of as "excess" deaths (Figure Two). If we examine the causes of these "excess" deaths in Hawaiians we find that in those 45 to 64 years of age, where the greatest excess of deaths occurs, that over half of these deaths are due to cardiovascular disease (Figure Three). There is, however, little scientifically gathered data on risk factors for cardiovascular disease in Hawaiians.

METHODS

In view of the lack of data on ethnic Hawaiians in this area, working closely with a native Hawaiian advisory group, a small CVD risk factor survey, funded by the Hawaii Heart Association and the Straub Foundation, of Hawaiians living on Hawaiian Homestead lands in the western and central portions of the island of Moloka'i, Hawaii was begun in 1985. As shown in Table One, 67% (250) of all individuals 20 to 59 years old were examined. Twenty five individuals who were not eligible due to age or residence were also examined. While a somewhat greater recruitment rate would have been ideal, financial constraints

have delayed further screening. It did not appear that we were more successful in recruiting those individuals who were already diagnosed as having increased risk. Some of the resistance to screening seemed to be due to the perception of some members of the population as to the political position of a number of the Hawaiians working with the study in regard to the issue of development of the island as a tourist area. Several instances of refusal due to fatalism in the face of diagnosed disease were reported. There were instances of individuals insisting they didn't want to know if they had the potential for heart disease. These types of individuals may have been under represented in our sample. However, while there were some potential biases in our recruitment, these did not seem to be likely to produce a sample greatly misrepresentative of the general Homestead population along health lines.

Moloka'i has a land area of 261 square miles. It's 1980 population was 6,049 with the largest population concentration being in the town of Kaunakakai with a population of 2,231. The population is largely rural in nature. At present more than 50 percent of the population of the island is part or pure native Hawaiian. This is the largest proportion of any of the major Hawaiian islands except for Ni'ihau. The island has only one major resort development and thus has experienced fewer of the problems associated with mass tourism than other islands. There is however, widespread unemployment due to the phasing out of the pineapple industry. The island has one small hospital and five general practitioners. In addition, a small number of specialists from Honolulu attend weekly clinics at the hospital and island residents regularly seek medical treatment on the islands of Oahu or Maui.

Those participating in the Moloka'i Heart Study were seen at a make shift clinic located in a room of the Community Recreational Center in Hoolehua, the largest homestead area on Moloka'i. These individuals primarily live in

extended family homes (Ohana) on homestead lands allocated by Federal law for long term lease to native Hawaiians). Individuals leasing this land must have proven themselves to of at least 50 percent native Hawaiian ancestry.

A period of extensive planning and making local contacts through our native Hawaiian co-investigator, Dr. Emmett Aluli, and our native Hawaiian Study Coordinator, Helen O'Connor preceded the study. A local advisory board named Na Pu'uwai for "many hearts" in the Hawaiian language was formed. This group, now incorporated as a nonprofit organization to promote Hawaiian health, was comprised of individuals influential in the Hawaiian community who subsequently advised and helped us with recruitment. Without this extensive "Hawaiian" input and help, the study could not have been carried out.

Before the study began a census of the individuals known to be living in the areas was done utilizing the knowledge of long time residents of the areas. Age and residency were checked by several members of our local advisory board, as well as being checked for age on hospital and clinic records and voter registration lists. The Hawaiian community is in a constant state of change as is any community. However, the Hawaiian culture is, perhaps more than others, characterized by the mobile extended family. Children, and other relatives, of all ages, moved out or in; recent deaths had occurred; some had moved off homestead land; and occasionally someone was forgotten. Our final census was, however, felt to be reasonably accurate for that period of time. Since we ended up visiting most homes in the areas, it was better than previous efforts.

There were initially some problems with getting people to the clinic for their appointments. Initially introductory letters, a mailed brochure, newspaper publicity and appointments made by phone were utilized. When these efforts were not as productive as hoped for, extensive phone contact and visits

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to homes by our Hawaiian staff and volunteers, to explain the project, were successful in the final weeks of the fieldwork. We had special problems with 20-29 year old men and women of whom at least 30% of the women were pregnant and thus excluded from the risk factor survey; and men in the 50-59 year old group where mortality had already thinned the ranks.

At the clinic appointment health and demographic questionnaires were administered: blood drawn for hemoglobin A-1-C, cholesterol and HDL-cholesterol measurements; height, weight and blood pressure measured; and a 24 hour urine collection for urine sodium and potassium initiated.

RESULTS

Being large in stature was associated with status in the pre-contact Hawaiian culture. As can be seen in Figure Four the Hawaiians examined in the current study tend to be overweight by Western standards when their mean Body Mass Indexes (Weight/Height^2) are compared to those from a group of Caucasians participating in the Minnesota Heart Survey in 1980-81.. Thus, approximately 65% were 20% or more and 35%, 40% or more, over the average Body Mass Index for Caucasians established by the National Center for Health Statistics for NHANES II analysis. The mean Waist/Hip ratio is higher than the standardly used cutpoint for Upper body fat predominance, of 0.80, in all age groups among the Hawaiians. This type of fat distribution has been reported to be independently associated with higher risk of subsequent cardiovascular disease than is lower body fat predominance which is common in other ethnic groups such as U.S. blacks.

As seen in Figure Five, among those examined approximately 34 percent of females were smokers as were 42 percent of males. Published data from the 1985 National Health Interview Survey Supplement on Health Promotion and Disease Prevention indicates that 33% of males and 28% of females over the age of 18

years smoke. Although sex specific data was not published, overall rates in that survey ranged from 30% in those 18 to 29 to 36% of those 30 to 34 and 31% of those 45 to 64 years. Among Hawaiians in the present study, smoking was most frequent in males and females in the 30-39 year old groups but consistently declined with increasing age in females whereas it did not in males.

The percent with hypertension (with a definition of systolic blood pressure greater than 140 mm Hg or a diastolic blood pressure of greater than 90 mm Hg, or taking antihypertensive medications) was approximately 13% in those 20-39 and 38% in those 40-59 (Figure Six). Among those individuals taking antihypertensive medications 81% of females and 90% of males did not have their blood pressures controlled (SBP> 140 or DBP >90). Although recent published data, gathered and tabulated in a comparable manner, is difficult to find, the Hawaiian rates of hypertension presented here appear to be substantially higher than those seen in Caucasian populations and of comparable magnitude to those seen in U.S. blacks. Data from a 1979 California statewide survey of the prevalence of hypertension in the various ethnic groups indicates that among males 18 to 49 years old, 15% of whites, 25% of blacks, 30% of Filipinos and 19% of Japanese had blood pressure elevations, defined as a systolic blood pressure of 140 mm Hg or a diastolic blood pressure of 90 mm Hg or greater. The rate for native Hawaiians 20 to 49 years old in this study was 25%.

As shown in Figure Seven serum cholesterol increased with age in both males and females. In males the prevalence of high cholesterol values, defined as serum cholesterols of 240 mg/dl or higher, ranged from 4% in those 20-29 to 46% of those 50-59 (Figure Eight). In males 10% of those 20-29 had such elevations, 41% of those 40-49 and 30% of those 50-59. It is hypothesized that

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this drop in older males may be due to a harvesting effect due to a large number of premature deaths from proven or apparent heart disease reported to have occurred in that older cohort in recent years.

Although laboratory and methodological differences make comparisons difficult the serum cholesterol values appear to be generally higher than those found in US whites in the Lipid Research Clinics study (Figure Nine). The mean HDL-cholesterol was between 37 to 42 mg/dl in all age groups and does not show a consistent age trend. These values are considerably lower than the values for whites found in the Lipid Research Clinics study indicating substantially higher risk for cardiovascular disease in Hawaiians.

As shown in Figure Ten, although we were unable to collect fasting blood specimens, there was glucose spillage in the urine or a history of diabetes in 2.8% of females and 3.5% of males 20-39 years of age. Among those 40-59 years of age 21% of both males and females had similiar findings. Somewhat higher rates of diabetes might be anticipated if a more sensitive screening tool were utilized. Among those 20-39 and 40-59 years of age, 10.5%, and 19% respectively had elevated alpha-1-C hemoglobins levels, indicating an increased probability of glucose intolerance or poor control of diabetes. Almost all known diabetics were under poor control as evidenced by spillage of glucose in the urine or very high glycohemoglobin levels.

Data from the 1979-81 National Health Interview Survey indicated that less than one percent of males and slightly over one percent of females, 17 to 44 years of age, in the general United States population, have a history of diabetes, while approximately 5.5% of each sex, in the age range 45-64 years, have such a history. The Hawaiian rates found here are substantially higher than those found in most other U.S. populations except some American Indian tribes in which comparable rates have been found.

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CONCLUSIONS

From these data, it would appear that this group of Hawaiians is at high risk of premature coronary heart disease and stroke due to elevated levels of hypertension, hypercholesterolemia, smoking and especially diabetes meletus. The relatively high prevalence of being overweight by Caucasian standards and the tendency for upper body fat predominance may contribute to this risk directly or through contributing to the high prevalence of the other risk factors. Hawaiian individuals in more urban environments might be expected to fare worse. In this population the majority of individuals found to have significant abnormalities in the cardiovascular disease risk factors studied were; unaware of them; were not under treatment; or did not have the condition under adequate control. Such findings probably indicate serious deficiencies in health care systems and the knowledge of the population about the associated disease processes. Studies which will further delineate the patterns of disease and risk in native Hawaiians and programs designed to help the Hawaiians to fight this new epidemic through a return of their diet and life-style to healthier patterns are urgently needed.

Na Pu'uwai, Inc., the native Hawaiian organization which grew out of the advisory board of the Moloka'i Heart Study, has taken on the task of seeking out ways to fulfill these and other needs in Hawaiian health as well as improving health on Moloka'i in general as it's stated mission. The group is now actively participating in planning for additional screening and is involved in delivering follow-up counseling to Moloka'i Heart Study participants as well as seeking ways to fund further programs and activities. They are also providing advice and encouragement to other Hawaiian communities considering organizing to improve their health.

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FIGURE 1

Life Expectancy at Birth by Ethnicity

Hawaii, 1920–1970

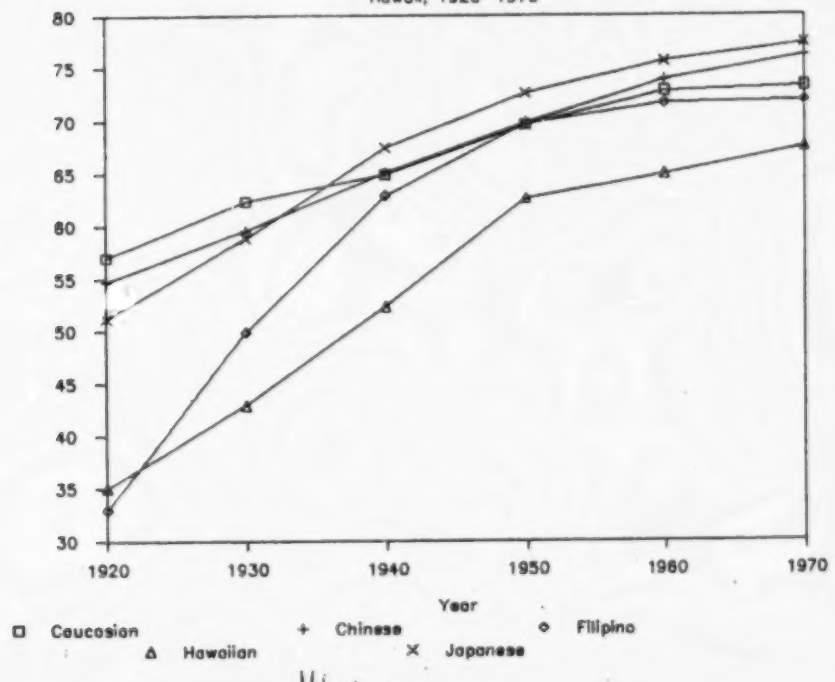

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TABLE 1

PATIENTS ENUMERATED AND SCREENED FOR THE
MOLOKAI HEART STUDY

AGE	FEMALE		MALE			
	ENUMERATED	SCREENED	ENUMERATED	SCREENED	ENUMERATED	SCREENED
20 - 29	47	26	41	29	88	55
30 - 39	56	43	42	29	98	72
40 - 49	50	34	49	35	99	69
50 - 59	45	27	39	27	84	54
TOTAL	198	130	171	120	369	250
TOTAL SCREENED LIVING OUTSIDE OF CENSUS AREA OR OVER AGE 59						25
TOTAL SCREENED						175

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FIGURE 2

EXCESS DEATHS PER YEAR IN HAWAIIANS

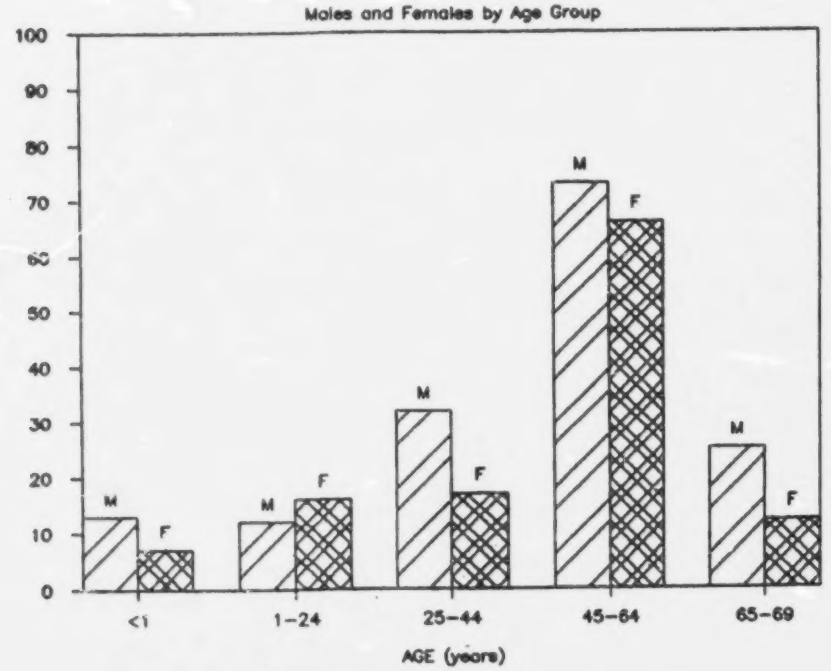

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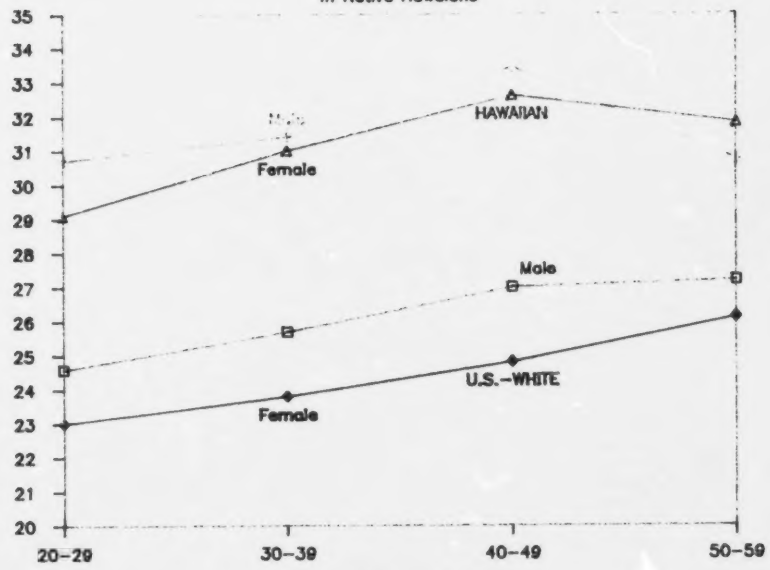
FIGURE 4

Mean Body Mass Index by Age and Sex

In Native Hawaiians



□ 1st point 25–29 yrs for U.S. whites

△ for Hawaiians

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FIGURE 5

Prevalence of Smoking by Age and Sex

in Native Hawaiians

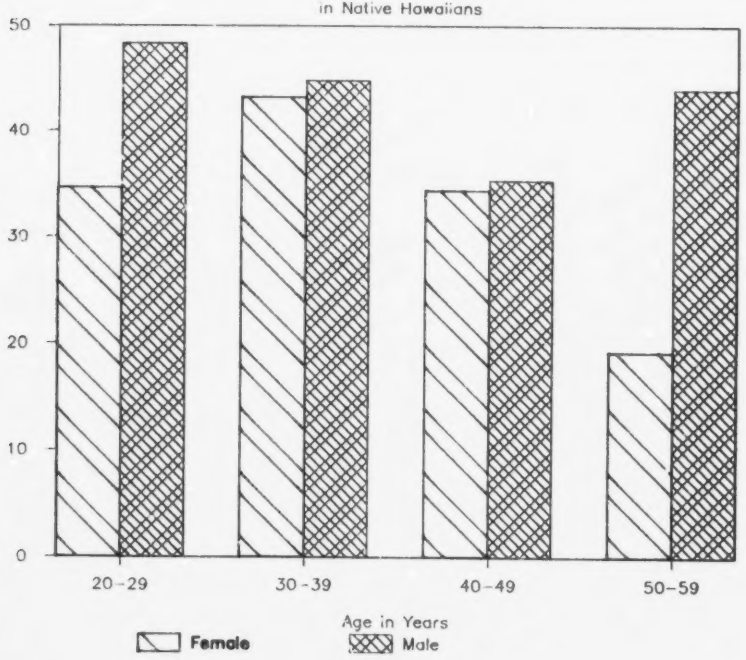

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FIGURE 6

Prevalence of Hypertension

in Native Hawaians by Age and Sex

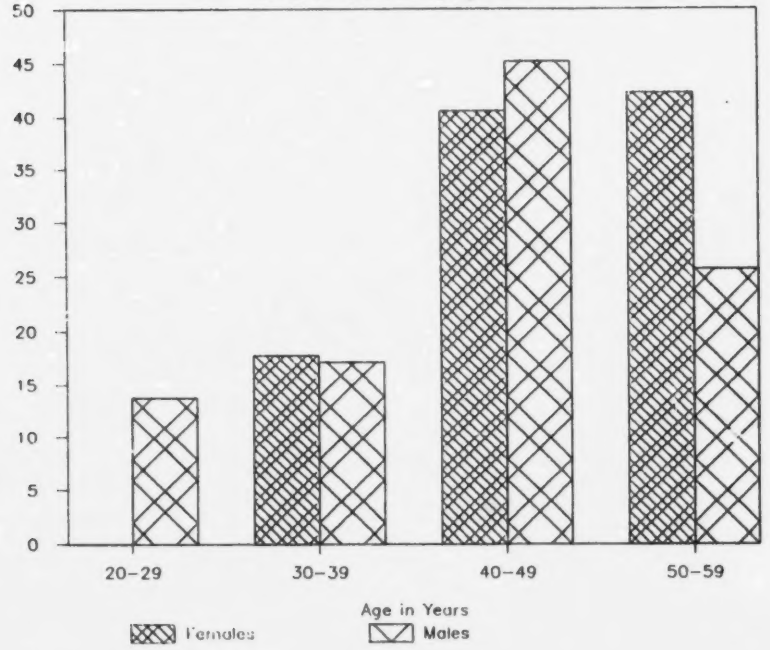

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FIGURE 7

Mean Serum Cholesterol by Age and Sex in Native Hawaiians

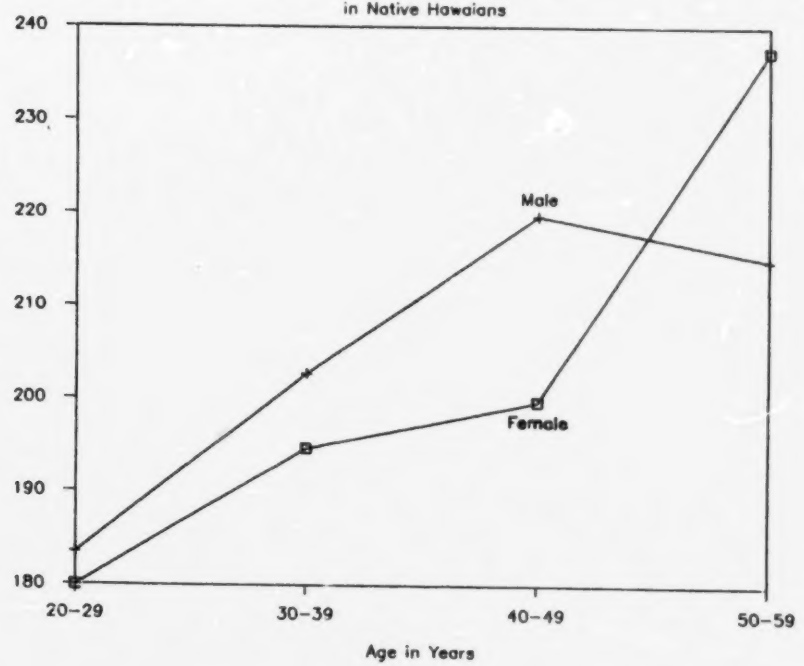

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FIGURE 3

EXCESS DEATHS PER YEAR IN HAWAIIANS
AGE 45 to 69 YEARS BY CAUSE OF DEATH

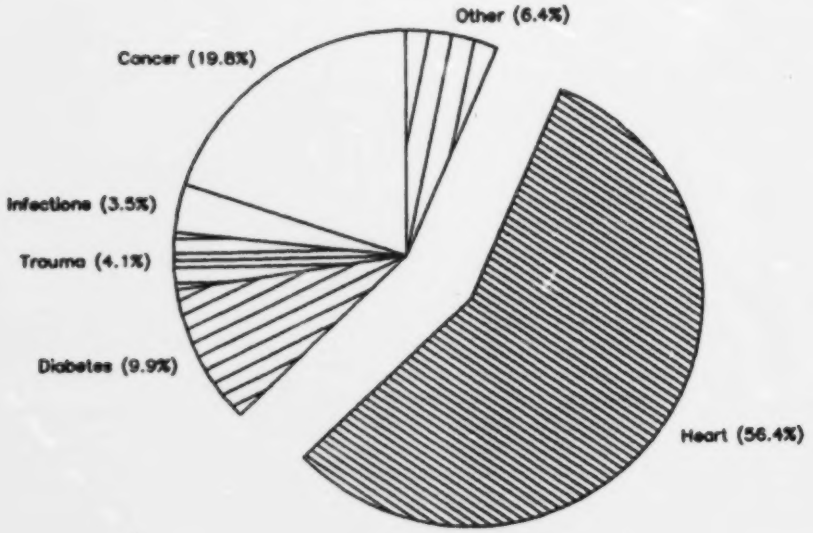

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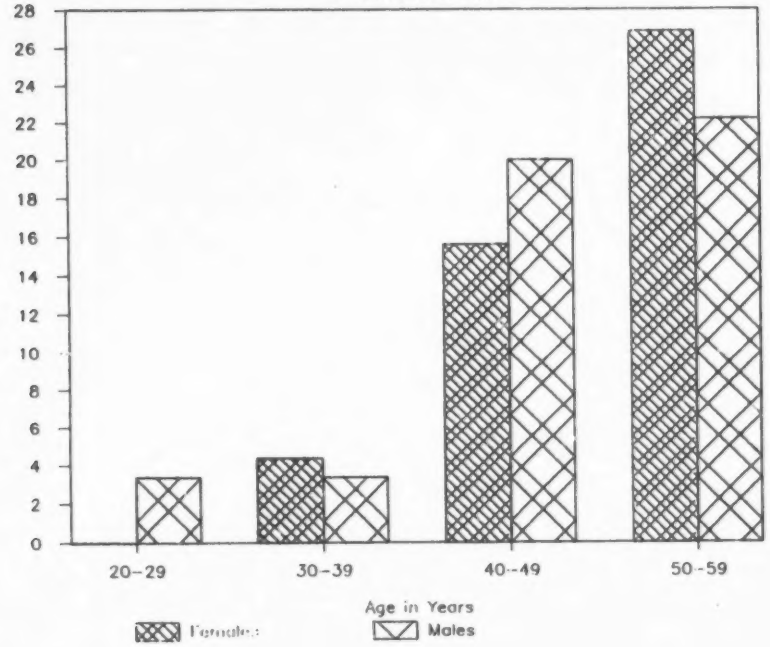
FIGURE 10

Diabetes Prevalence by Age and Sex

in Native Hawaians



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Prepared Statement Of

Claire Kuuleilani Hughes
Dietitian and Public Health Nutritionist
Honolulu, Hawaii

Aloha 'auinalā oukou, Chairman Andrews and members of the Senate Select Committee on Indian Affairs. My name is Claire Kuuleilani Hughes. I am of native Hawaiian ancestry and, by profession, I am a Registered Dietitian and Public Health Nutritionist. I speak on behalf of the Association of Hawaiian Civic Clubs and E Ola Mau, which is a permanent group of Native Hawaiian health professionals whose purpose is to insure improved health conditions among Native Hawaiians.

I speak in support of Senate Bill 2243, the bill addresses the health status of Native Hawaiians.

The Alu Like report indicates that Native Hawaiians can expect to suffer more, and more severely, from most chronic illness and can expect to die six to ten years earlier than any other ethnic group living in our native land, Hawaii. We agree with Section 1, (3) of the Bill which provides for any efforts "to raise the health status of Native Hawaiians to the highest possible level and to encourage the maximum participation of Native Hawaiians in the planning and management of health services to achieve the objective" of betterment of the conditions of Native Hawaiians.

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Section 1 of the Bill accurately states the Native Hawaiian ~~has~~ have the highest age-sex mortality rate; a lower life expectancy; a higher rate of infant mortality, congenital abnormalities and underweight infants; greatest risk of diabetes, heart disease, and ~~other~~ some forms of cancer; earlier ages for the onset of diabetes, heart disease, and hypertension; have significantly higher rates of heart disease and hypertension; highest cancer rates; poorest survival rates from cancer; rank the highest in poor maternal health; highest rate of suicide among young adults and elderly; highest peridontal disease rates and the poorest dental hygiene; have a higher proportion of alcohol and narcotics use and school performance impairment; higher levels of stress; under-representation in rates of participation in health education, health promotion, screening, and referral programs; utilization of mental health services; under-represented in the health professions. Some of the factors which contribute to the development of these conditions are poor socio-economic status, stress, poor health practices in addition to high fat intakes high sugar intates and high alcohol consumption.

Sound nutrition plays a key role in prevention and treatment of heart disease, hypertension, diabetes, cancer and dental caries, as well as, in the improved pregnancy outcomes of reducing the occurrence of low birth weights, congenital conditions and underweight infants. Adequate nutrition can insure healthy growth and development in young children and assist in the prevention and amelioration of chronic conditions in the adult. We have no data on the current nutritional status of the Native Hawaiian. We are unable to identify the daily dietary practices of the Native Hawaiian that may lead to ill health and chronic disease.

Since the last ~~major~~ nutrition study in 1954, major changes have occurred in Hawaii's food supply. Hawaii now has a wide array of frozen foods and

dehydrated foods. Almost all of the nationally known fast food restaurants are here in Hawaii. There is a high availability of salty-fatty snack foods, soft drinks and sweet beverages and we have one of the highest per capita consumptions of alcoholic beverages in the United States. Traditional native foods are now less available and far more costly than ever before.

In recent attempts to recreate the ancient Hawaiian diet, research dietitians found it difficult to get the calories from fat and oils up to 14 per cent of total calories. Compare this with the typical American diet which contains 42 per cent fat (data from Senate Select Committee's: United States Dietary Goals. 1974) and the 38 per cent in the typical Hawaii-State diet (data from 1977-78 USDA Nationwide Food Consumption Survey). In other words the ancient Hawaiian ate a very low fat diet and the Native Hawaiian of today consumes somehwere between 38 per cent to 42 per cent of their calories in animal fat, more than three times the fat of his ancestors. Recent evaluation of the fat in fast foods indicated the wide usage of animal fat, which contains cholesterol and saturated fat, in food production. French fries are now a popular food item in Hawaii. A personal survey of ingredients in commercially prepared cookies, sweets and snack foods, frequently used in child feeding, showed lard and saturated fats to be a common ingredient. Overconsumption of fat, especially cholesterol and saturated fat, is in the development of heart disease, several cancers, hypertension and obesity.

Another major change from the traditional Hawaiian dietary practices is the high intake of sugary foods which starts early and continues throughout life. High sugar intakes increase the risk of overweight, which can lead to some forms of heart disease and dental caries.

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Section 3 of the Bill provides for establishing a program of health promotion and disease prevention designed to serve the Native Hawaiian population. Maximum participation of the Native Hawaiian in the planning, development, implementation and monitoring of an approach specific to the Hawaiian is essential in assurance of its acceptability and accessability. Addressed in Section 3 (a) (2) (G), is the training of para professionals only. However, training for health professionals at all levels of care, is essential for success of such a program. Research, data collection and careful health planning are important to the understanding of risk factors occurring in the Native Hawaiian Community and planning for prevention of disease in this group.

Thank you for the opportunity to make this presentation in support of Senate Bill 2243 in behalf of E Ola Mau and the Association of Hawaiian Civic Clubs.

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U.S. DIETARY GOALS *

1. To avoid overweight, consume only as much energy (calories) as is expended; if overweight, decrease energy intake and increase energy expenditure. (See pages xxxiii–xxxiv, 7–10, 15, 58.)
2. Increase the consumption of complex carbohydrates and "naturally occurring" sugars from about 28 percent of energy intake to about 48 percent of energy intake. (See pages xxxv, 11–16.)
3. Reduce the consumption of refined and processed sugars by about 45 percent to account for about 10 percent of total energy intake. (See pages xxxv, 27–33.)
4. Reduce overall fat consumption from approximately 40 percent to about 30 percent of energy intake. (See pages 35–38.)
5. Reduce saturated fat consumption to account for about 10 percent of total energy intake; and balance that with poly-unsaturated and mono-unsaturated fats, which should account for about 10 percent of energy intake each. (See pages 39–41.)
6. Reduce cholesterol consumption to about 300 mg. a day. (See pages xxxv–xxxix, 42, 43.)
7. Limit the intake of sodium by reducing the intake of salt to about 5 gram a day. (Pages xxxix, 49–51.)

The Goals Suggest the Following Changes in Food Selection and Preparation:

1. Increase consumption of fruits and vegetables and whole grains. (See pages 17–26.)
2. Decrease consumption of refined and other processed sugars and foods high in such sugars. (See pages 33, 34.)
3. Decrease consumption of foods high in total fat, and partially replace saturated fats, whether obtained from animal or vegetable sources, with poly-unsaturated fats. (See pages 43–48.)
4. Decrease consumption of animal fat, and choose meats, poultry and fish which will reduce saturated fat intake. (See pages xxxix–xli, 43–48, and use particularly, tables 11–13, pp. 45–48.
5. Except for young children, substitute low-fat and non-fat milk for whole milk, and low-fat dairy products for high fat dairy products. (See pages 43–48.)
6. Decrease consumption of butterfat, eggs and other high cholesterol sources. Some consideration should be given to easing the cholesterol goal for pre-menopausal women, young children and the elderly in order to obtain the nutritional benefits of eggs in the diet. (See pages xxxvii–xxxix for more details concerning eggs and cholesterol, pp. 43–48.)
7. Decrease consumption of salt and foods high in salt content. (See page 51 and Appendix E.)

Persons with physical and/or mental ailments who have reason to believe that they should not follow guidelines for the general population should consult with a health professional having expertise in nutrition, regarding their individual case.

Although the dietary goals are stated in terms of specific levels, each specific level should be considered as the center of a range (see p. xxvi in the Preface for details.)

While there may be a tendency to read only the summaries provided on these two pages, the Select Committee recommends that, whenever possible, the entire report be read in order to obtain a more complete perspective of the relationship between diet and health.

The question of whether dietary changes alone such as those suggested in these goals can reduce the leading causes of death in the United States remains controversial. Individuals, in exercising freedom of dietary choice, should recognize that these dietary recommendations do not *guarantee* improved protection from the killer diseases. They do, however, increase the *probability* of improved protection.

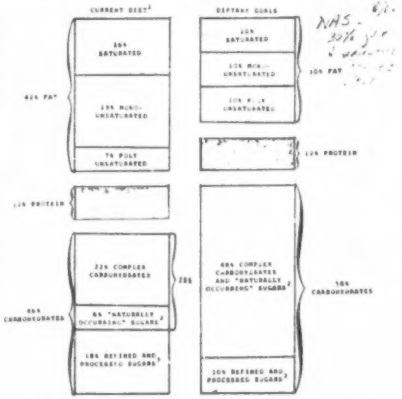

FIGURE 1

[1] These percentages are based on calories from food and nonalcoholic beverages. Alcohol adds approximately another 210 calories per day to the average diet of drinking age Americans.

[2] "Naturally occurring" Sugars which are indigenous to a food as opposed to refined (cane and beet) and processed (corn sugar, syrups, molasses and honey) sugars which may be added to a food prior to consumption.

[3] In many ways alcoholic beverages affect the diet in the same way as refined and other processed sugars. Both add calories (energy) to the total diet but contribute little or no vitamins or minerals.

Sources for current diet: Changes in Nutrients in the U.S. Diet Caused by Alterations in Food Intake Patterns by Friend, Agricultural Research Service, U.S. Department of Agriculture, 1974. Proportions of saturated versus unsaturated fats based on unpublished Agricultural Research Service data.

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*Reprinted from DIETARY GOALS FOR THE UNITED STATES: 1st edition; Prepared by the Staff of the SELECT COMMITTEE ON NUTRITION AND HUMAN NEEDS UNITED STATES SENATE; December 1974; U.S. Government Printing Office, Washington 1974

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Prepared Statement

By: Naleen N. Andrade, M.D., Chief Psychiatry Resident
University of Hawaii John A. Burns School of Medicine.
Member of Hawaiian Health Research Consortium

Aloha auwinala ia oukou apau. Good afternoon to all of you. My name is Naleen Andrade. I am a Native Hawaiian born, raised and educated in the Hawaiian Islands. I am also a physician and presently the Chief Psychiatry Resident at the University of Hawaii School of Medicine. Today I would like to share with you some of the findings of our Mental Health Task Force.

You have a copy of our Mental Health Task Force Report which represents a thorough evaluation of all published and unpublished reports on Native Hawaiian mental needs, as well as results of surveys conducted to supplement the findings of these reports. For the sake of brevity, I will not subject you to a presentation of the statistical analysis, validity or bulk of the data which you can read from our report. Instead I will summarize our findings.

General Findings

The study indicated that, in comparison to statewide population estimates, Native Hawaiians have:

1. Higher proportions of social problems with family, people, and children, including higher proportions of assaultive acts and antisocial behavior;
2. Higher proportions of alcohol and narcotics use;
3. Higher proportions of school performance impairment;
4. Higher rates of suicide among young adult and elderly males;
5. Higher rates of child abuse and neglect (second only to Samoan populations);
6. Higher rates of residence in correctional institutions;
7. Higher rates of academic failure and poor school performance; and
8. Higher levels of stress as indexed by leading stress markers including poverty, educational level, single family households, dwelling density, and so forth.

The study also revealed that Native Hawaiian under-utilize mental health services because they are unacceptable as presently structured and delivered because they fail to accommodate Native Hawaiian values and life styles. There is little use of Hawaiian values and norms as treatment goals, there is little use of Hawaiian beliefs to describe problems, there is little awareness of Hawaiian cultural beliefs and practices regarding health, and there is little use of Hawaiian language terms in health care.

Our Task Force Report proposed an Interactional Framework (Marsella, 1979) to conceptualize the Native Hawaiian Mental Health situation, as well as exploring what has been called the "Culture Loss/Stress Syndrome" (Final Report of the Native Hawaiian Educational Assessment Project from Kamehameha Schools/Bishop Estate). Both theoretical models are based on a hypothesis that modern day Hawaiians are predisposed to maladaptive behavioral patterns as a result of historical changes over the last two centuries which have devalued and sometimes perverted Hawaiian traditions. These traditions or belief systems - not unlike Western thought or tradition which has influenced American Democracy - are essential to the way native Hawaiians deal with the world around them.

Historically with the coming of the Haole (the Hawaiian generic equivalent of the white man) in 1778, the Hawaiian way of life was catastrophically altered. Manifest Destiny had a catacylsmic impact upon the Hawaiians. Isolated for centuries, they had no immunity to the diseases brought in on ships. As a result, the population which had numbered about 300,000 in 1778, was decimated to 28,000 by the end of the nineteenth century. From such suffering came the Hawaiian saying, "Na kanaka 'oku'u wale aku no i kau 'uhane", "the people dismissed freely their souls and died."

The influence of the New England missionaries (who came in 1820) upon Hawaiian Society was considerable: "In religion, the Congregational Church replaced the old system; in finance and economics, many of the descendants of the missionaries eventually dominated the business community; in education, the missionaries put the Hawaiian language into print" (McDermott et al) (disregarding several consonants, thus phonetically altering our language) and in politics, the sons of missionaries in 1893 led the Hawaiian revolution.

As a psychiatrist who incorporates the principles of Psychosomatic Medicine into my clinical work, I would like to further expand the Interactional and Culture Loss/Stress Syndrome Models to include Engel's (1977) Biopsychosocial Model. In this way one is able to perceive people as having Biological, Psychological and Social Health Care Needs; as well as appreciating the history that has influenced the development of those people. Superficially this seems to be too complicated a framework, however I believe this kind of perception is in line with the holistic (if I may use that overworked term) nature of Native American Health Care practices. In order to personalize what I have been speaking about, I would like at this time to present a case that anecdotally illustrates this theoretical framework.

I was asked to do a cultural consult on a 34-year-old Native Hawaiian man who was thought to be a possibly psychotic by his haole therapists because he spoke of ancestral spirits and Hawaiian medicine rituals.

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FIGURE 8

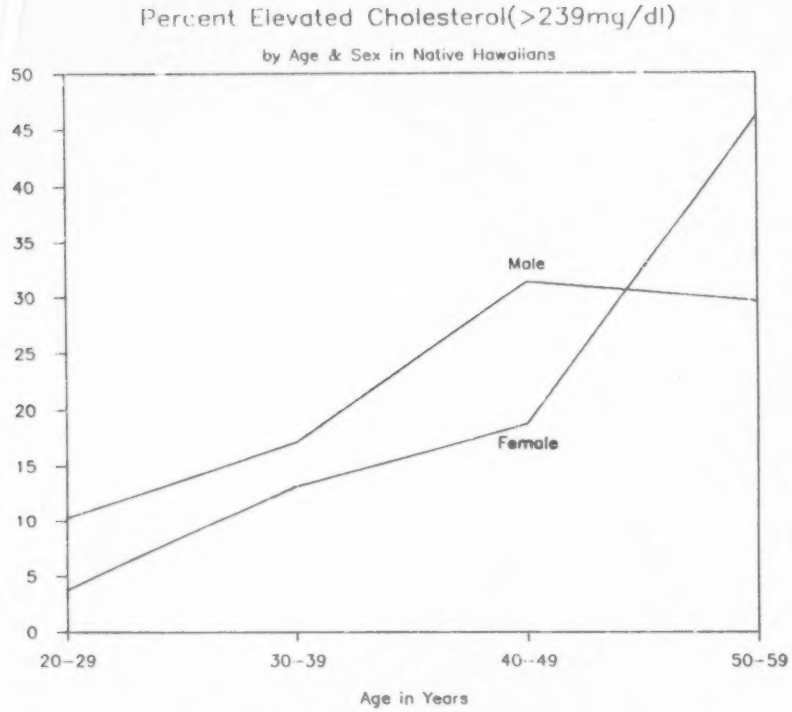
Percent Elevated Cholesterol(>239mg/dl)
by Age & Sex in Native Hawaiians
50
45
40
35
30
25
20
15
10
5
0
Male
Female
20-29
30-39
40--49
50-59
Age in Years

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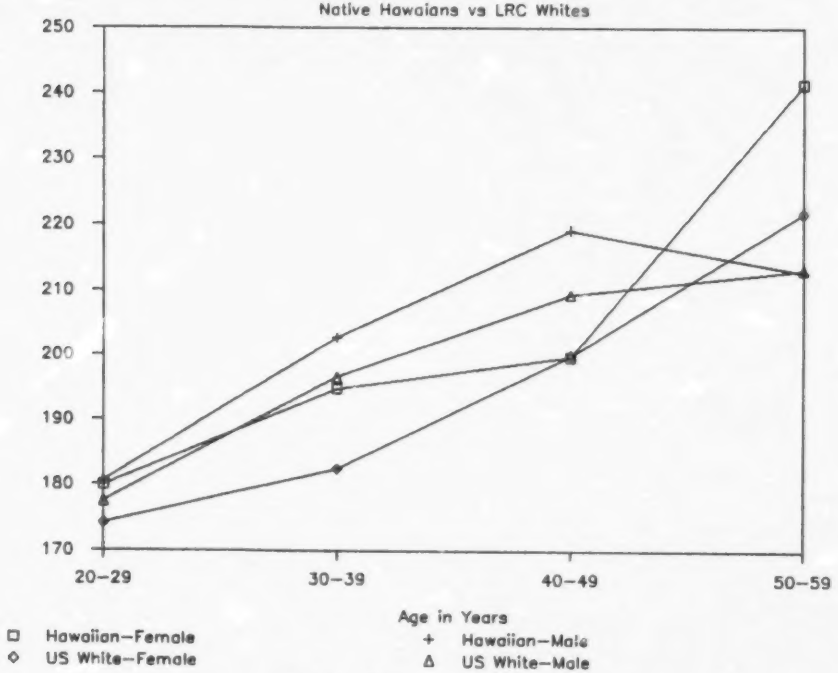
FIGURE 9

Mean Serum Cholesterol by Age and Sex

Native Hawaians vs LRC Whites



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My evaluation indicated that he was not psychotic. But, what was impressive was his self-concept of what was an average Hawaiian and also how fragmented (and sometimes erroneous) his knowledge of Hawaiian history and culture was.

He perceived himself as "an average Hawaiian". He was unemployed, suffering from chronic depression and a lower back injury, he came from a broken home where he had been physically abused as a child, he was divorced with two children and was a spouse abuser, he had alcohol problems and a history of both suicidal and homicidal behavior. His description of the ancestral spirit and medicine rituals he followed were largely in accord with ancient Hawaiian beliefs. However, there was a consistent misnaming of Hawaiian concepts, and unbeknownst to him, a striking syncretism between Hawaiian and Haole beliefs. Because of this, his struggle to differentiate between the two cultures, and thus attain a cultural (Hawaiian) identity was totally frustrated. This seems tragic to me in a man who is 3/4ths Native Hawaiian.

The treatment of this patient consisted of my working with his Haole therapists. Together we combined Native Hawaiian and Western or Haole cultural and psychiatric beliefs. Through this process, we were able to cognitively reframe this man's concept of himself and help him integrate his Haole and Hawaiian beliefs. Today he no longer abuses drugs, he has a job, a stable relationship and is attending college part-time. This successful treatment of a typical yet extremely difficult mental health case indicates that by combining Western and Hawaiian concepts, we can offer an invaluable - sometimes even curative - alternative to mental and emotional suffering.

Our Hawaiian people are suffering and in great need of relief and research. The Hawaiian Health Bill S.2243 represents a priceless opportunity to expand the kind of treatment I discussed earlier and have an impact upon the future, if not the very survival of our Hawaiian People.

I have been impressed with the selfless dedication expressed in your work toward helping Native Americans, and I am impressed by the passion that energizes your endeavors. As Native Hawaiians and as fellow Americans we need your support as we too strive to claim our right toward life, liberty, and the pursuit of happiness.

Thank you very much!

STATEMENT OF DR. TERENCE ROGERS, DEAN OF THE JOHN A. BURNS SCHOOL OF MEDICINE AT THE UNIVERSITY OF HAWAII

MR. CHAIRMAN AND MEMBERS OF THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS.

I AM TERENCE ROGERS, DEAN OF THE JOHN A. BURNS SCHOOL OF MEDICINE AT THE UNIVERSITY OF HAWAII. I AM GRATEFUL FOR THE OPPORTUNITY TO TESTIFY BOTH ON SENATE BILL S.2243 BOTH IN GENERAL AND WITH RESPECT ESPECIALLY TO SECTION 4, REGARDING COMMUNITY HEALTH CENTER AND SECTION 5 REGARDING THE HEALTH SERVICE SCHOLARSHIP PROGRAM.

IT IS APPROPRIATE TO MENTION, THAT, WITH YOUR SUPPORT, WE HAVE BEEN ABLE TO MAINTAIN AN AGGRESSIVE AFFIRMATIVE ACTION PROGRAM TO EDUCATE YOUNG NATIVE HAWAIIANS, OF BOTH SEXES, AS PHYSICIANS. TO DATE, WE HAVE GRADUATED ABOUT 60 NATIVE HAWAIIAN MEDICAL DOCTORS AND HAVE FURTHERMORE 25 IN THE THE PIPELINE. THIS IS NOT AN "ADD-ON" MINORITY PROGRAM BUT WAS AN INTEGRAL PART OF THE ORIGINAL PLANNING FOR THE SCHOOL'S MISSION. THE SCHOLARSHIP PROGRAM PROPOSED IN THE BILL WOULD BE A GREAT ASSET IN THIS CONTEXT. I WOULD ALSO MENTION THAT ALL POST GRADUATE MEDICAL TRAINING IN HAWAII IS CARRIED OUT UNDER THE AEGIS OF THE MEDICAL SCHOOL AND THAT THESE

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RESIDENTS AND FELLOWS WOULD BE PART OF THE "INFANTRY" IN DELIVERING THE ACTUAL MEDICAL CARE INVOLVED IN A HAWAIIAN COMMUNITY HEALTH CENTER. AGAIN, A PROPORTION OF THE RESIDENTS ARE THEMSELVES HAWAIIAN, EPITOMIZED BY DR. NALEEN ANDRADE WHO TESTIFIES TODAY. SHE HAS BEEN OUR CHIEF RESIDENT IN PSYCHIATRY SINCE JULY 1985 AND IN JULY 1986 SHE WILL BECOME ASSISTANT PROFESSOR OF PSYCHIATRY. SHE CAME TO HER M.D. ALL THE WAY THROUGH OUR MINORITY OPPORTUNITIES PROGRAM AND HAS BEEN ONE OF THE MOST SATISFACTORY STUDENTS, RESIDENTS, AND HUMAN BEINGS IT HAS BEEN OUR GOOD FORTUNE TO RECRUIT.

OUR DEPARTMENT OF MEDICINE, WITH THE GREATEST COOPERATION OF THE QUEEN'S MEDICAL CENTER HAS "TAKEN OVER" THE CARE AT THE QUEEN EMMA CLINIC, THE MAJOR INNER CITY CLINIC WITH A LARGE HAWAIIAN CLIENTELE. THIS PROCESS COULD BE EXTENDED AND CONTAIN A UNIQUELY HAWAIIAN SUB-PROGRAM WITH THE KIND OF SUPPORT THIS BILL WOULD PROVIDE.

THE THRUST OF THE FOREGOING REMARKS IS THAT WE ARE ALREADY INVOLVED IN THE ACTUAL DELIVERY OF CARE TO THE ECONOMICALLY-STRESSED HAWAIIAN COMMUNITY AND HAVE REAL SKILLS AND ORGANIZATION TO OFFER. WE HAVE ENOUGH NATIVE HAWAIIAN TALENT IN THE UNIVERSITY OF HAWAII TO SET UP, FOR EXAMPLE, A TREATMENT AND SUPPORT CENTER DIRECTED AT ALCOHOLISM IN WHICH THE HAWAIIAN PATIENTS WOULD ENCOUNTER ONLY HAWAIIAN HEALTH PROFESSIONALS. MR. MYRON THOMPSON, A TRUSTEE OF THE BISHOP ESTATE, AND I HAVE HAD EXTENSIVE DISCUSSIONS ABOUT THE

OMINOUS EPIDEMIOLOGICAL PICTURE AMONG HAWAIIANS ALLUDED TO IN THE BILL. OUR RAPPORT IS SUCH THAT WE IN THE MEDICAL SCHOOL WOULD BE VERY COMFORTABLE WITH HIS SERVING, FOR EXAMPLE, AS AN INTERFACE WITH THE HAWAIIAN ORGANIZATIONS.

WE REGARD IT AS AN INTEGRAL PART OF OUR MISSION, AND THE VISION OF THE LATE GOVERNOR BURNS, TO PARTICIPATE IN THE PROGRAMS THIS BILL WILL MAKE POSSIBLE. IT WOULD BE DIFFICULT TO DO THIS, HOWEVER, IF THE MEDICAL SCHOOL FACULTY AND HOUSE-STAFF WERE SIMPLY THE "HIRED-HELP" IN A HEALTH PROGRAM; IT WOULD BE NECESSARY FOR THE MEDICAL SCHOOL TO HAVE A MAJOR ROLE IN POLICY DEVELOPMENT AND IMPLEMENTATION.

ALTHOUGH I MAY HAVE NOT HAD AN OPPORTUNITY TO DISCUSS IT SPECIFICLLY WITH HIM, I KNOW I CAN SPEAK FOR DEAN JERROLD MICHAEL OF OUR UNIVERSITY'S SCHOOL OF PUBLIC HEALTH, IN THEIR HAVING A SHARED INTEREST IN THE BILL, ESPECIALLY REGARDING HEALTH PROMOTION AND DISEASE PREVENTION.

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STATE OF HAWAII
OFFICE OF HAWAIIAN AFFAIRS
567 SOUTH KING STREET, SUITE 100
HONOLULU, HAWAII 96813
(808) 548-[illegible]

PREPARED STATEMENT OF KAMAKI A. KANAHELE, III, ADMINISTRATOR,
OFFICE OF HAWAIIAN AFFAIRS

Good morning Mr. Chairman and members of the Committee. My name is Kamaki Kanahele III, and I am the Administrator of the Office of Hawaiian Affairs (OHA). I would like to thank Senator Mark Andrews, Chairman of this Committee, for scheduling this important hearing. The Office of Hawaiian Affairs strongly supports adoption of Senate Bill 2243.

Before continuing, however, I would like to share with you a little background on the Office of Hawaiian Affairs as a means of providing the members of the Committee with some understanding of the role and interest of OHA in this matter.

THE OFFICE OF HAWAIIAN AFFAIRS

According to legislation creating the Office of Hawaiian Affairs, it is the "principal public agency in (Hawaii) responsible for the performance, development, and coordination of programs and activities relating to native Hawaiians." It is governed by a nine-member native Hawaiian Board of Trustees elected by approximately 44,000 native Hawaiians. As a result, the OHA trustees are directly accountable to their beneficiaries, the native Hawa'ian people.

OHA was created in 1978 by an amendment to the Hawaii State Constitution. The basis for its establishment, however, dates back to our State Admission Act of 1959. The Act created a public land trust, the proceeds of which were to be used for five purposes. One of the purposes was the betterment of conditions for native Hawaiians.

In 1979 the State Legislature passed Act 196 which established the basic structure of OHA. This act was subsequently codified as Chapter 10, Hawaii Revised Statutes. For your convenience, a copy of Chapter 10 is attached as Appendix A. It mandates OHA to serve as a receptacle for reparations and to act as a clearinghouse for federal or state assistance involving Hawaiian programs and projects. OHA is also responsible for advising, informing and coordinating federal, state and county activities relating to native Hawaiian programs. It is with this role in mind that OHA submits this testimony today.

HAWAIIAN HEALTH NEEDS

Recently a consortium of both native Hawaiian and health-related agencies worked cooperatively to produce a report on Hawaiian health needs called, E Ola Mau: Native Hawaiian Health Needs Study. Native Hawaiian agencies that participated in the study included OHA; Alu Like, a private nonprofit group whose Board is elected by 9,000 native Hawaiians; and the State Department of Hawaiian Home Lands, whose main mission is to lease homestead lands to eligible native Hawaiians.

The study focused on mental health, medical, nutrition and dental problems of the native Hawaiian population. It also examined the historical and cultural context of native Hawaiian health needs. In terms of mental health, the study found that native Hawaiians have higher rates of social problems, including assaultive acts and antisocial behavior; alcohol and

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narcotics use; child abuse and neglect; and residence in correctional institutions. The medical section of the study confirms the findings of the two reports previously mentioned. In addition, it reports that native Hawaiians have higher rates of congenital abnormalities; underweight infants; chronic diseases such as diabetes, heart disease, hypertension and cancer; teen pregnancy; illegitimate births and inadequate prenatal care. The nutrition/dental section of the study found that the native Hawaiian diet was deficient in protein, phosphorous, iron, vitamins C and A and thiamine. In addition, native Hawaiians consumed too much fats, sugars and salt. The caries attack rate in Hawaii for permanent teeth among children 6-14 years of age is one of the highest in the nation, and native Hawaiian children had one of the highest DMF (decayed, missing and filled teeth) rates.

A recent OHA survey has found that communities with a high concentration of native Hawaiians appear to have limited availability of health care services. For example, of 270 health care programs recently surveyed by OHA, only three (3) serve the Waianae Coast, Oahu, which has a native Hawaiian population of 15,000 or 46% of the population there. The island of Molokai, whose population is 45% native Hawaiian, lacks programs for chronic conditions, communicable diseases and victims of abuse: problems which are prevalent in the native Hawaiian communities. Clearly native Hawaiians are not receiving the health care services that are needed.

MEETING THE NATIVE HAWAIIAN HEALTH NEEDS

Because of the dire health statistics enumerated above, Senate Bill 2243 is particularly important to the native Hawaiian community. The services and programs proposed in the bill (health promotion and disease prevention; community health centers; health service scholarships; and health needs

assessments, health education and health services referrals) can go a long way in improving the health condition of native Hawaiians.

The manner in which these services and programs are planned and delivered, however, is extremely crucial. It is important to overcome cultural barriers that may have previously prevented native Hawaiians from receiving health services that could have prevented or treated medical problems. To help overcome these barriers, native Hawaiians should participate in the creation and control of health care services that will be provided in their communities and native Hawaiian traditions and culture should be incorporated into any proposed programs or services. For example, education/prevention programs can be offered in conjunction with existing native Hawaiian organizations which will increase the success of the program by implicitly providing the approval and support of the social environment of the individual. Family support can be crucial in health care also. Therefore, working with the families as well as native Hawaiian community organizations may be an important aspect of providing health care.

The training of native Hawaiians to become health care providers is also important to ensure the native Hawaiian patients' acceptance of the health care provider. The provision of health service scholarships to native Hawaiians would increase the number of native Hawaiians in the health care field, in which they are so sorely under-represented, and assure that the health care provider is sensitive to the native Hawaiian and his culture.

SUMMARY

In summary, I would like to reiterate OHA's support for the adoption of Senate Bill 2243. There are many serious health problems in the native Hawaiian community, and Senate Bill 2243 would make it possible for native

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Hawaiians to address these problems by planning for and controlling health care services to meet their health needs.

The Office of Hawaiian Affairs would like to express its appreciation to this Committee for allowing us the opportunity to provide testimony on this most important subject.

ATTACHMENT

Appendix A: Chapter 10, Hawaii Revised Statutes

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by any student attending any elementary, intermediate, high school, college, or university in the State.

Recognition shall be through the sponsoring of student art exhibits and the granting of scholarships, monetary awards, or certificates to the student whose art work is being recognized. Any funds appropriated to the foundation may be used for the recognition of student art work. Student art work recognized under this section may be acquired for the purpose of temporary or permanent display in state buildings and public facilities pursuant to section 103-8. [L 1977, c 112, pt of §2]

[§9-5] Rules. The foundation shall adopt rules in consultation with the comptroller for the purposes of administering this chapter. Such rules shall be adopted in accordance with chapter 91. [L 1977, c 112, pt of §2]

CHAPTER 9C
ETHNIC STUDIES

[Repealed]

§§9C-1, 2 REPEALED. L 1977, c 14, §2.

Cross References

Ethnohistory studies, see §9-3(10).

[CHAPTER 10]
OFFICE OF HAWAIIAN AFFAIRS

SECTION

[10-1] DECLARATION G.. PURPOSE
[10-2] DEFINITIONS
[10-3] PURPOSE OF THE OFFICE
[10-4] OFFICE OF HAWAIIAN AFFAIRS: ESTABLISHED; GENERAL POWERS
[10-5] BOARD OF TRUSTEES; POWERS AND DUTIES
[10-6] GENERAL DUTIES OF THE BOARD
[10-7] BOARD OF TRUSTEES
[10-8] ORGANIZATION; QUORUM; MEETING
10-9 COMPENSATION; EXPENSE
[10-10] ADMINISTRATOR; APPOINTMENT, TENURE, REMOVAL
10-11 SALARY OF THE ADMINISTRATOR
[10-12] ASSISTANT; STAFF
10-13 APPROPRIATIONS; ACCOUNTS; REPORTS
[10-13.5 USE OF PUBLIC LAND TRUST PROCEEDS]
10-14 BUDGET, AUDITING
[10-15] ANNUAL REPORT
[10-16] SUITS

Attorney General Opinions

Office of Hawaiian affairs constitutionally valid. Att. Gen. Op. 80-8.

Legislature may not authorize office of Hawaiian affairs to use funds derived from public land trust to better the conditions of "Hawaiians", as defined in section 10-2, distinguishing from "native Hawaiians" as defined in section 5(f) of the Admission Act. Att. Gen. Op. 83-2.

[§10-1] Declaration of purpose. (a) The people of the State of Hawaii and the United States of America as set forth and approved in the Admission Act, established a public trust which includes among other responsibilities, betterment of conditions for native Hawaiians. The people of the State of Hawaii reaffirmed their solemn trust obligation and responsibility to native Hawaiians and furthermore declared in the state constitution that there be an office of Hawaiian affairs to address the needs of the aboriginal class of people of Hawaii.

(b) It shall be the duty and responsibility of all state departments and instrumentalities of state government providing services and programs which affect native Hawaiians and Hawaiians to actively work toward the goals of this chapter and to cooperate with and assist wherever possible the office of Hawaiian affairs. [L 1979, c 196, pt of §2]

[§10-2] Definitions. In this chapter, if not inconsistent with the context:

(1) "Office" means the office of Hawaiian affairs;

(2) "Board" means the board of trustees;

(3) "Administrator" means the administrator of the office of Hawaiian affairs;

(4) "Native Hawaiian" means any descendant of not less than one-half part of the races inhabiting the Hawaiian Islands previous to 1778, as defined by the Hawaiian Homes Commission Act, 1920, as amended; provided that the term identically refers to the descendants of such blood quantum of such aboriginal peoples which exercised sovereignty and subsisted in the Hawaiian Islands in 1778 and which peoples thereafter continued to reside in Hawaii;

(5) "Hawaiian" means any descendant of the aboriginal peoples inhabiting the Hawaiian Islands which exercised sovereignty and subsisted in the Hawaiian Islands in 1778, and which peoples thereafter have continued to reside in Hawaii;

(6) "Beneficiary of the public trust entrusted upon the office" means native Hawaiians and Hawaiians. [L 1979, c 196, pt of §2]

[§10-3] Purpose of the office. The purposes of the office of Hawaiian affairs include:

(1) The betterment of conditions of native Hawaiians. A pro rata portion of all the funds derived from the public land trust shall be funded in an amount to be determined by the legislature for this purpose, and shall be held and used solely as a public trust for the betterment of the conditions of native Hawaiians. For the purpose of this chapter, the public land trust shall be all proceeds and income from the sale, lease, or other disposition of lands ceded to the United States by the Republic of Hawaii under the joint resolution of annexation, approved July 7, 1898 (30 Stat. 750), or acquired in exchange for lands so ceded, and conveyed to the State of Hawaii by virtue of section 5(b) of the Act of March 18, 1959 (73 Stat. 4, the Admissions Act), (excluding therefrom lands and all proceeds and income from the sale, lease, or disposition of lands defined as "available lands" by section 203 of the Hawaiian Homes Commission Act, 1920, as amended), and all proceeds and income from the sale, lease, or other disposition of lands retained by the

United States under sections 5(c) and 5(d) of the Act of March 18, 1959, later conveyed to the State under section 5(e);

(2) The betterment of conditions of Hawaiians;

(3) Serving as the principal public agency in this State responsible for the performance, development, and coordination of programs and activities relating to native Hawaiians and Hawaiians; except that the Hawaiian Homes Commission Act, 1920, as amended, shall be administered by the Hawaiian homes commission;

(4) Assessing the policies and practices of other agencies impacting on native Hawaiians and Hawaiians, and conducting advocacy efforts for native Hawaiians and Hawaiians;

(5) Applying for, receiving, and disbursing, grants and donations from all sources for native Hawaiian and Hawaiian programs and services; and

(6) Serving as a receptacle for reparations. [L 1979, c 196, pt of §2]

[§10-4] Office of Hawaiian affairs; established; general powers. There shall be an office of Hawaiian affairs constituted as a body corporate which shall be a separate entity independent of the executive branch. The office, under the direction of the board of trustees, shall have the following general powers:

(1) To adopt, amend, and repeal by-laws governing the conduct of its business and the performance of the powers and duties granted to or imposed upon it by law;

(2) To acquire in any lawful manner any property, real, personal, or mixed, tangible or intangible, or any interest therein; to hold, maintain, use, and operate the same; and to sell, lease, or otherwise dispose of the same at such time, in such manner and to the extent necessary or appropriate to carry out its purpose;

(3) To determine the character of and the necessity for its obligations and expenditures, and the manner in which they shall be incurred, allowed, and paid, subject to provisions of law specifically applicable to the office of Hawaiian affairs;

(4) To enter into and perform such contracts, leases, cooperative agreements, or other transactions with any agency or instrumentality of the United States, or with the State, or with any political subdivision thereof, or with any person, firm, association, or corporation, as may be necessary in the conduct of its business and on such terms as it may deem appropriate;

(5) To execute, in accordance with its by-laws, all instruments necessary or appropriate in the exercise of any of its powers; and

(6) To take such actions as may be necessary or appropriate to carry out the powers conferred upon it by law. [L 1979, c 196, pt of §2]

[§10-5] Board of trustees; powers and duties. The board shall have the power in accordance with law to:

(1) Manage, invest, and administer the proceeds from the sale or other disposition of lands, natural resources, minerals, and income derived from whatever sources for native Hawaiians and Hawaiians, including all income and proceeds from that pro rata portion of the trust referred to in section 10-3, of this chapter;

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(2) Exercise control over real and personal property set aside to the office by the State of Hawaii, the United States of America, or any private sources, and transferred to the office for native Hawaiians and Hawaiians;
(3) Collect, receive, deposit, withdraw, and invest money and property on behalf of the office;
(4) Formulate policy relating to the affairs of native Hawaiians and Hawaiians, provided that such policy shall not diminish or limit the benefits of native Hawaiians under Article XII, section 4, of the state constitution;
(5) Otherwise act as a trustee as provided by law;
(6) Delegate to the administrator, its officers and employees such powers and duties as may be proper for the performance of the powers and duties vested in the board;
(7) Provide grants to public or private agencies for pilot projects, demonstrations, or both, where such projects or demonstrations fulfill criteria established by the board;
(8) Make available technical and financial assistance and advisory services to any agency or private organization for native Hawaiian and Hawaiian programs, and for other functions pertinent to the purposes of the office of Hawaiian affairs. Financial assistance may be rendered through contractual arrangements as may be agreed upon by the board and any such agency or organization; and
(9) Adopt and use a common seal by which all official acts shall be authenticated. [L 1979, c 196, pt of §2]

[§10-6] General duties of the board. (a) The general duties of the board shall be:
(1) To develop, implement, and continually update a comprehensive master plan for native Hawaiians and Hawaiians which shall include, but not be limited to, the following:
  (A) Compilation of basic demographic data on native Hawaiians and Hawaiians;
  (B) Identification of the physical, sociological, psychological, and economic needs of native Hawaiians and Hawaiians;
  (C) Establishment of immediate and long-range goals pursuant to programs and services for native Hawaiians and Hawaiians;
  (D) Establishment of priorities for program implementation and of alternatives for program implementation; and
  (E) Organization of administrative and program structure, including the use of facilities and personnel;
(2) To assist in the development of state and county agency plans for native Hawaiian and Hawaiian programs and services;
(3) To maintain an inventory of federal, state, county, and private programs and services for Hawaiians and native Hawaiians and act as a clearinghouse and referral agency;
(4) To advise and inform federal, state, and county officials about native Hawaiian and Hawaiian programs, and coordinate federal, state, and county activities relating to native Hawaiians and Hawaiians;
(5) To conduct, encourage, and maintain research relating to native Hawaiians and Hawaiians;

(6) To develop and review models for comprehensive native Hawaiian and Hawaiian programs;

(7) To act as a clearinghouse for applications for federal or state assistance to carry out native Hawaiian or Hawaiian programs or projects;

(8) To apply for, accept and administer any federal funds made available or allotted under any federal act for native Hawaiians or Hawaiians; and

(9) To promote and assist the establishment of agencies to serve native Hawaiians and Hawaiians.

(b) The board shall have any powers which may be necessary for the full and effective performance and discharge of the duties imposed by this chapter, and which may be necessary to fully and completely effectuate the purposes of this chapter. [L 1979, c 196, pt of §2]

[§10-7] Board of trustees. The office of Hawaiian affairs shall be governed by a board to be officially known as the board of trustees, office of Hawaiian affairs. Members of the board shall be elected in accordance with chapter 13D, with reference to sections 11-15, 11-25, 12-5, [and] 12-6, and vacancies shall be filled in accordance with section 17-7. [L 1979, c 196, pt of §2]

Revision Note

Bracketed "and" was added.

[§10-8] Organization; quorum; meeting. The board, at its first meeting after an election, shall elect from its own membership a chairperson and a vice-chairperson who shall serve a term of two years. Their election shall be immediately certified by the board to the lieutenant governor.

A majority of all members to which the board is entitled shall constitute a quorum to do business. The concurrence of a majority of all members to which the board is entitled shall be necessary to make any action of the board valid; provided that due notice shall be given to all members.

Meetings shall be called and held at the call of the chair or by a quorum, as often as may be necessary for transaction of the board's business. The board shall meet at least once annually on each of the islands of Hawaii, Maui, Molokai, Lanai, Kauai, and Oahu. [L 1979, c 196, pt of §2]

§10-9 Compensation; expense. Members of the board shall be allowed:

(1) Compensation at the rate of $50 a day for each day's actual attendance at meeting;

(2) Transportation fares between islands and abroad; and

(3) Personal expenses at the rates specified by section 78-15, while attending board meetings or while on official business as authorized by the chairperson, when such board meetings or official business shall require a member to leave the island upon which the member resides. [L 1979, c 196, pt of §2; am L 1981, c 148, §1]

Note. L 1981, c 148, amended this section employing the Ramseyer format, but omitted, without setting out in brackets, the former last paragraph which read: "All payments for compensation, travel, and expenses shall be paid by warrants signed by the chairperson of the board."

Amendment Note

L 1981 amended section generally.

[§10-10] Administrator; appointment, tenure, removal. The board by a majority vote, shall appoint an administrator who shall serve without regard to the provisions of chapters 76 and 77 for a term to be determined by the board. The board, by a two-thirds vote of all members to which it is entitled, may remove the administrator for cause at any time. [L 1979, c 196, pt of §2]

§10-11 Salary of the administrator. The salary of the administrator shall be established by the board; provided that such salary shall not exceed the salary of department heads or executive officers established by law. The administrator shall be included in any benefit program generally applicable to officers and employees of the State. [L 1979, c 196, pt of §2; am L 1981, c 130, §2]

Amendment Note

L 1981 amended first sentence.

[§10-12] Assistant; staff. The administrator may employ and retain such officers and employees as may be necessary, subject to the approval of the board, to carry out the functions of the office. Such officers and employees may be hired without regard to chapters 76 and 77, and shall serve at the pleasure of the administrator. Officers and employees of the office of Hawaiian affairs shall be included in any benefit program generally applicable to officers and employees of the State. [L 1979, c 196, pt of §2]

Cross References

Services of volunteers, see §90-1.

§10-13 Appropriations; accounts; reports. Moneys appropriated by the legislature for the office shall be payable by the director of finance, upon vouchers approved by the board, or by any officer elected or appointed by the board and authorized by the board to approve such vouchers on behalf of the board. All moneys received by or on behalf of the board shall be deposited with the director of finance and kept separate from moneys in the state treasury; except that any moneys received from the federal government or from private contributions shall be deposited and accounted for in accordance with conditions established by the agencies or persons from whom the moneys are received; and except that with the concurrence of the director of finance, moneys received from the federal government for research, training, and other related purposes of a transitory nature, and moneys in trust or revolving funds administered by the office, shall be deposited in depositories other than the state treasury and shall be reported on to the state comptroller under section 40-81, and rules prescribed thereunder. Income derived from the sale of goods or services and income from lands and property as described in section 10-3, shall be credited to special or other funds; provided that upon the recommendation of the office, the comptroller shall establish such other separate accounts or special funds for other designated revenues as may be directed by the

board or its authorized representative. [L 1979, c 196, pt of §2; am L 1981, c 37, §2]

Amendment Note

L 1981 added reference to §40-81.

[§10-13.5 Use of public land trust proceeds.] Twenty per cent of all funds derived from the public land trust, described in section 10-3, shall be expended by the office, as defined in section 10-2, for the purposes of this chapter. [L 1980, c 273, §1]

§10-14 Budget, auditing. (a) Not less than twenty days before the legislature convenes in every odd-numbered year, the board shall submit to the legislature and to each member thereof, a budget which shall contain the recommendations of the board for the succeeding two fiscal years.

(b) Not less than twenty days before the legislature convenes in an even-numbered year, the board may submit to the legislature a supplemental budget to amend any appropriations for the current fiscal biennium or prior fiscal periods.

(c) The office shall be subject to government audit. [L 1979, c 196, pt of §2; am L 1982, c 224, §2]

Note. For budgetary guidelines, see L 1983, c 202, §6.

Amendment Note

L 1982 rewrote section.

[§10-15] Annual report. The board shall prepare and make public their annual report which shall include an enumeration of their activities, income, and expenditures during the year. The annual report shall be submitted to the governor and the legislature ten days prior to the convening of each regular session of the legislature. The board shall prepare and submit special reports as may be required by the legislature. [L 1979, c 196, pt of §2]

[§10-16] Suits. (a) The office may sue and be sued in its corporate name. The State shall not be liable for any acts or omissions of the office, its officers, employees, and the members of the board of trustees, except as provided under subsection (b).

(b) In matters of tort, the office, its officers and employees, and the members of the board shall be subject to suit only in the manner provided for suits against the State under chapter 662.

(c) In matters of misapplication of funds and resources in breach of fiduciary duty, board members shall be subject to suit brought by any beneficiary of the public trust entrusted upon the office, either through the office of the attorney general or through private counsel.

(d) In matters involving other forms of remedies, the office, its officers and employees, and the members of the board shall be subject to suit as provided by any other provision of law and by the common law. [L 1979, c 196, pt of §2]

Severability, see L 1979, c 196, §11.

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PREPARED STATEMENT OF THE AMERICAN NURSES' ASSOCIATION AND HAWAII NURSES ASSOCIATION BY GENEVIEVE LEHUANANIOKILAUEA KINNEY, R.N., PH. D.

Mr. Chairman, I am Genevieve Lehuananiokilauea Kinney, a registered nurse with a Ph.D. in Transcultural Nursing. I am Director of Nursing Programs at the University of Hawaii at Hilo and a member of the Hawaii Nurses Association (HNA) which is a constitutent of the American Nurses' Association (ANA), where I serve on the Cabinet on Professional Nursing Education. I am appearing today on behalf of the ANA and Hawaii Nurses Association and its 3000 professional nurse members. HNA is the spokesperson for the 7500 registered nurses of Hawaii who provide health care services in hospitals, homes, and the community.

Nurses are a vital resource in providing access to essential health services for all population groups. They are especially vital in assuring that underserved minority populations receive necessary health care and utilize and participate in the health care delivery system.

Nursing has long recognized the concept of cultural diversity at all levels of nursing practice. The E Ola Mau Native Hawaiian Health Needs Study reiterates what nurse researchers have documented, that monocultural approaches to health care are ineffective in meeting health and nursing needs of diverse cultural groups of patients.

We would like to commend the chairperson and the Committee for recognizing the critical need that S.2243 addresses. We also applaud Senator Inouye for his commitment to nursing and his recognition of the

importance and contribution of nursing research. Funding for nursing research which began at one million now stands at 14.5 million.

ANA established its Council on Cultural Diversity in Nursing Practice to focus on cultural diversity in American society as it impacts on the academic discipline of nursing, the profession of nursing, and the delivery of nursing care. The council promotes nursing research on the relationship of cultural diversity to health beliefs and practices and health care delivery, the dissemination of such information through nursing education, its implementation in nursing practice and the development of future study.

HNA and ANA whose members represent the largest group of health care providers in the country are very concerned with the findings regarding Native Hawaiian health. It is distressing that although health care systems exist for the state of Hawaii, they are underutilized by the native population. Our review of the findings indicates that many of the devastating health problems could be eradicated or drastically reduced by present basic health care concepts. Disease prevention, health promotion and health education are major factors to be addressed for an effective health care policy for native Hawaiians.

Nursing can play a major role in the assessment of the population's needs as they are present in all aspects of the community. Nurses have provided care in Hawaii and within the Hawaiian community for the last one hundred years. HNA has witnessed the gradual decline of health among all ages of the population with the development of a

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more complex health care system.

Indigenous Hawaiians have had a difficult time adopting culturally to a health care model that is foreign to their cultural and spiritual healing beliefs and practices. The current health care system is based predominately in the private sector on the delivery of acute care services. While the public sector is based on non-acute care services both of these systems lend themselves to a health care model in which the consumer is expected to assertively seek access to those services.

At the time of the study, nursing care delivery to the Hawaiian population was not addressed, although nurses are often the transcultural link between the underutilized services and the Hawaiian in need. That omission may have occurred because there was no apparent nursing representation on the consortium established to address the issues of the study. Such information would be important because nursing's intervention has been demonstrated to prevent long term or catastrophic illnesses.

The Hawaii Nurses Association has recognized that health care professionals are predominately non-Hawaiian and a trans-cultural gap exists between those providers and native Hawaiians. HNA has conducted two transcultural nursing conferences during the last three years which have been very successful and plans to continue its efforts to eradicate cultural barriers to health care. Nursing recognizes that transcultural awareness must be implemented through a multi-disciplinary approach.

A number of areas, e.g. Molokai, have lost obstetrics and gynecologic services because of the malpractice crisis. At the present time, one nurse midwife, with a supervising physician, is providing those services. Similarly public health nurses who provide community services are stretched to the maximum. Two public health nurses have a caseload of 400 patients each. They provide immunizations, well baby care and minimum home health care for the elderly.

There is a large group of Hawaiians between the ages of 5 to 60 years who lack skilled nursing care. One community health clinic is expected to close because of economic losses. This will increase the gap in health care services. Necessary follow-up care is not occurring because a patient may only have one initial contact with the health care system. Chronic understaffing at acute care facilities exists on other islands which compounds the problem.

These problems exist because monocultural approaches promote the use of western medicine as the appropriate delivery system. However, the hospital, clinic or private physician do not provide the necessary alternatives in services, delivery system, conceptualization of illness and treatment modalities. Nurses can facilitate less costly alternatives that are within the total cultural belief system. Nursing's development of new protocols for care can also serve as models for other health disciplines. The use of health care providers identified within the cultural group as well as services such as massage, ceremonial rites, herbs, acupuncture, acupressure, etc. may be less costly and more effective for the native Hawaiian.

Section 3(a)(2)(6) and 5(a) of S.2243 are vital as the utilization of nurses from culturally diverse groups will result in integration of cultural and allopathic systems of care into the delivery system. As the first native Hawaiian to benefit from the Minority Fellowship Program of ANA, I know those persons also function in an advisory capacity and as teachers to colleagues in nursing and other health disciplines. Native Hawaiian nurses are in an unique position to assist both patient and health care providers as they understand the health care system of the majority culture in addition to a culturally diverse health care system.

Section 4(a)(1), authorizing community health centers developed by native Hawaiian organizations, is necessary to affect outreach of those not in a delivery system. Access to care can be improved by providing relevant, compatible, responsive services. Individuals need choices of delivery systems in seeking health care. Delivery systems in or close to their own neighborhoods, in which language is not a barrier, in which there are nurses who understand cultural background and responses to illness are very important issues to determine whether people believe they have access to care.

Nurses are in an important position to provide alternative health services to culturally diverse clients. They have a background in community and home health care which fosters the design of accessible health services. They are versed in both the psychological and physical aspects of illness. They have knowledge of human development and family systems which complements health care delivery. Additional

knowledge in the area of cultural diversity would enable nurses to be the most likely persons to provide a range of health care service alternatives to clients.

The expression of illness in any cultural group includes the study of the symptoms of illness. Illness can be expressed through somatic, psychological, social, and spiritual symptoms. A group's reaction to pain differs from culture to culture as does the willingness of group members to disclose information about their health and illness. The expression of illness can differ widely from what Western health professionals are accustomed to making.

The healing and curing of illness includes knowledge of the nature of healing, the range of remedia, preferred remedies, practices for regaining health, nutritional preferences, range of system(s) of care utilized, and preferred care givers.

Finally, beliefs and practices about death and dying differ from culture to culture. These beliefs and practices apply to the sanctity of life, the preservation of life, and the acceptance of death. Ceremonies surrounding death and dying may differ, as may the customs surrounding bereavement and mourning. Cultural differences cannot be addressed without attention to discrimination. Responsive nursing care is not just a matter of recognizing cultural differences, of designing and implementing culturally compatible services, or of understanding minority cultural values. Responsive nursing care also includes attention to the discrimination that exists in the delivery system of health care to cultural minorities.

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Discrimination based on cultural differences influences the perceptions, values and beliefs of a group in addition to the cultural differences themselves. Discrimination based on cultural differences is apparent in all aspects of society, including the health care delivery system. The reluctance of many culturally diverse groups to utilize health services may be due to cultural differences in defining illness and prescribing its treatment or to cultural differences in attitude toward services. Another plausible explanation for this phenomenon is that some culturally diverse groups may experience racial prejudice or discrimination in the health delivery system and may avoid services because of distrust or suspicion. Discrimination and prejudice in the health delivery system may be present in health policy-making as well as in individual acts.

Health care givers from many professional groups have noted that tne single most important aspect of providing health care to cultural minorities is to educate health professionals who share the culture and language of the client. This same statement can be made about nursing. Nursing care that is responsive to cultural differences requires a knowledge of culture. It also requires the integration of cultural minority nurses into the health care delivery system through increased education and training.

Specific to the profession of nursing, the ANA Council on Cultural Diversity stresses the active recruitment of individuals of culturally diverse groups into the profession, and the provision of opportunities for advancement and influence within the profession. In the area of

delivery of care, the council supports equal access to quality care for culturally diverse groups, and the devising of delivery systems to meet their needs.

Through ANA and state associations, nurses work to meet the health care needs of underserved peoples and encourages members of minority groups to enter nursing and to actively participate in the profession. The Ethnic/Racial Minority Fellowship Programs were established to further this process. ANA has contributed to the development of ethnic/minority nurses in nursing by administering two federally funded projects that assist them in earning doctoral degrees with either a clinical or a research focus in the social and behavioral sciences. Since 1974, many of our fellows have gained experience by working in Senatorial and Congressional offices. Fellowships have been awarded to 122 nurses, 70 of whom have earned doctorates. Those nurses can be expected to assume leadership roles in nursing practice, education, and research, and to make significant contributions to the knowledge of, and the services to groups disenfranchised by the health care system.

CONCLUSION

Mr. Chairman, these hearings represent what we hope is a solid commitment to improve the health status of Native Hawaiians who have sustained the impact of 200 years of oppression, cultural and economic change so that they can be full participants in the life the United States has provided to those who colonized their lands.

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PREPARED STATEMENT OF BERNADETTE PANG, UNIVERSITY OF HAWAII SCHOOL OF NURSING

MR. CHAIRMAN, AND MEMBERS OF THE SUBCOMMITTEE, I WOULD LIKE TO THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU. MY NAME IS BERNADETTE PANG AND I AM REPRESENTING THE UNIVERSITY OF HAWAII SCHOOL OF NURSING. I AM A PROFESSIONAL REGISTERED NURSE AND EDUCATOR WHO HAS BEEN INVOLVED IN NURSING FOR OVER 17 YEARS. MORE IMPORTANT, I AM OF NATIVE HAWAIIAN ANCESTRY.

IN LIGHT OF THE STAGGERING HEALTH NEEDS OF NATIVE HAWAIIANS, I AM SAD TO REPORT THAT THERE ARE ONLY A FEW NURSES WHO ARE OF NATIVE HAWAIIAN ANCESTRY. AS AN ETHNIC GROUP, HAWAIIANS ARE UNDER-REPRESENTED IN ALL THE HEALTH PROFESSIONS.

I COME BEFORE THE MEMBERS OF THIS COMMITTEE TO ASK FOR YOUR SUPPORT OF SENATE BILL 2243. IN 1984, MARGARET HECKLER, THEN THE SECRETARY OF HEALTH AND HUMAN SERVICES, REPORTED THAT AMERICANS ARE LIVING LONGER AND INFANT MORTALITY HAD DECLINED. HOWEVER, THIS HAS NOT BEEN THE CASE FOR MINORITIES. SECRETARY HECKLER'S TASK FORCE ON BLACK AND MINORITY HEALTH EXPOSED A DISPARITY IN THE BURDEN OF DEATH AND ILLNESS AMONG MINORITIES AS COMPARED TO OUR NATION'S POPULATION AS A WHOLE. THE NATIVE HAWAIIAN HEALTH NEEDS STUDY GIVES FURTHER SUPPORT TO THIS DISPARITY. THE CURRENT HEALTH SYSTEM HAS FAILED TO ADDRESS AND IMPROVE THE HEALTH STATUS OF NATIVE HAWAIIANS. IT HAS BECOME APPARENT THAT THE HEALTH PLIGHT OF THE HAWAIIAN PEOPLE IS THE RESULT OF HISTORIC AND CULTURAL FACTORS.

THERE ARE SEVERAL REASONS WHY WE SUPPORT THE SENATE BILL 2243:

FIRST, THE BILL ADDRESSES THE NEED FOR THE DEVELOPMENT OF A HEALTH DELIVERY SYSTEM THAT WILL BE ACCESSIBLE AND ACCEPTABLE. IT INCORPORATES THE LIFE STYLE AND VALUES OF THE HAWAIIAN PEOPLE SO THAT CULTURALLY ACCEPTABLE METHODS ARE DEVELOPED TO PROMOTE HEALTH AND REDUCE DISEASE.

SECONDLY, THIS BILL REQUIRES THE INVOLVEMENT OF NATIVE HAWAIIAN COMMUNITIES AND ORGANIZATIONS POSSESSING UNIQUE INSIGHTS INTO THEIR OWN HEALTH PROBLEMS. THESE ORGANIZATIONS AND COALITIONS ARE IMPORTANT AND PRACTICAL RESOURCES BECAUSE THEY HAVE GRASSROOT SUPPORT, ENABLING THEM TO HAVE A FINGER ON THE PULSE OF THE HEALTH NEEDS OF THE HAWAIIAN PEOPLE. GIVEN THIS INPUT, THESE ORGANIZATIONS ARE ABLE TO INCREASE THE MOTIVATION AND PARTICIPATION OF THE HAWAIIAN PEOPLE IN ORDER TO IMPROVE THEIR HEALTH STATUS.

THIRDLY, THIS BILL PROVIDES FOR A HEALTH TRAINING COMPONENT TO INCREASE NATIVE HAWAIIAN REPRESENTATION IN ALL LEVELS OF HEALTH CARE. THERE SHOULD BE PARTICULAR EMPHASIS ON INCREASED PARTICIPATION IN THE NURSING

PROFESSION, BASED ON THE TRADITIONAL ROLE THAT NURSES HAVE PERFORMED AS HEALTH CARE PROVIDERS AND IN THE PREVENTION OF HEALTH PROBLEMS. MORE THAN OTHER HEALTH PROFESSIONALS, NURSES HAVE ESTABLISHED A UNIQUE RECORD OF PROVIDING HEALTH CARE TO UNDERSERVED POPULATIONS. IN ORDER TO FURTHER THIS SERVICE TO NATIVE HAWAIIANS, THE NURSING PROFESSION IS IN NEED OF INCREASED FEDERAL GOVERNMENT SUPPORT. THE DEVELOPMENT OF NATIVE HAWAIIAN HEALTH PROFESSIONALS WHO ARE CULTURALLY SENSITIVE PROVIDES FOR ROLE MODELS AND IS ESSENTIAL TO IMPROVING HEALTH CARE. IN ADDITION, THIS BILL MAKES PROVISIONS FOR CULTURAL AWARENESS TRAINING FOR NON-NATIVE HAWAIIAN HEALTH CARE PROVIDERS.

MR. CHAIRMAN, WE ARE ENGAGED IN AN URGENT BATTLE AGAINST POOR HEALTH AND THE DEATH OF A PEOPLE IN THEIR OWN NATIVE LAND. MEMBERS OF THIS SELECT COMMITTEE AND CONGRESS CAN CLAIM VICTORY IN IMPROVING THE QUALITY OF LIFE AND HEALTH OF NATIVE HAWAIIANS BY SUPPORTING S.2243. FAILURE TO SUPPORT THIS BILL WOULD MEAN A RETREAT FROM A RESPONSIBLE HEALTH CARE POLICY THAT WILL HAUNT US WITH SPIRALING HEALTH CARE COSTS AND THE TRAGIC LOSS OF A GENTLE PEOPLE. THIS BILL REPRESENTS THE TURNING POINT OF OUR GOVERNMENT IN MEETING ITS RESPONSIBILITIES AND OBLIGATIONS. AS A NURSE OF HAWAIIAN ANCESTRY, I STRONGLY BELIEVE I CANNOT ASK OTHERS TO HELP NATIVE HAWAIIANS IF I DO NOT DO EVERYTHING IN MY POWER TO HELP THEM. BUT I KNOW THAT MY EFFORTS ALONE CANNOT CONQUER THE HEALTH PROBLEM. COMBATING THE EFFECTS OF ILLNESS AND DISEASE CAN ONLY BE ACHIEVED WITH BOTH THE HEART AND A HELPING HAND.

MR. CHAIRMAN, THE HEALTH STATUS OF NATIVE HAWAIIANS IS DEPENDENT ON YOUR LEADERSHIP AND THE SUPPORT OF THE MEMBERS OF THIS SELECT COMMITTEE.

I THANK YOU AND THE MEMBERS OF THIS SELECT COMMITTEE FOR THE SUPPORT SHOWN IN THE PAST AND HOPE FOR YOUR CONTINUED SUPPORT IN THE FUTURE.

PREPARED STATEMENT OF THE AMERICAN DIABETES ASSOCIATION

The American Diabetes Association (ADA) is pleased to submit its views on S. 2243, a bill designed to improve the health of Native Hawaiians. The ADA is the nation's leading voluntary health organization representing the interests of over 11 million Americans with diabetes through the work of over 800 affiliates and chapters. The twofold mission of the ADA is to promote the search for a preventive and cure for diabetes and to improve the well-being of people with diabetes and their families.

The Need for S. 2243

The problem of diabetes within the Native Hawaiian population is indeed a severe one. As noted in E Ola Mau, the recent Native Hawaiian health needs study funded by the Department of Health and Human Services, Native Hawaiians were found to have the highest incidence of diabetes of any ethnic group in the State of Hawaii and one of the highest rates of incidence of any subpopulation in the United States. Further confirmation of the extremely high incidence of diabetes among Native Hawaiians is provided by the Department of Health and Human Services' Report of the Secretary's Task Force on Black and Minority Health. Current efforts to address the growing rates of incidence and adverse health impacts of diabetes among Native Hawaiians are inadequate. The ADA therefore wholeheartedly supports the enactment of S. 2243, which would substantially expand current federal and state efforts to combat the problem of diabetes among Native Hawaiians.

The evidence linking diabetes and Native Hawaiians is cause for deep concern. As stated in E Ola Mau:

- o Native Hawaiians suffer from diabetes and its complications far more frequently than other population groups in Hawaii;
- o Native Hawaiians have had the highest mortality rate from diabetes compared to other subpopulations within the state;
- o the increased frequency of diabetes is associated with age over 45, Hawaiian ethnicity, residence in a rural location, and a lower-income background;
- o those Native Hawaiians with less than twelve years of completed education have higher incidences of diabetes than those with more education;
- o Native Hawaiians are often diagnosed as having diabetes at later stages in life, making treatment more difficult;
- o resistance to seeking treatment and lack of proper diagnostic and treatment services account for lack of timely diagnosis of diabetes; and
- o current screening procedures for diabetes among Native Hawaiians is difficult since they violate cultural practices.

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Specific Comments on S. 2243

The provisions of S. 2243 represent a welcome and most needed approach to addressing the particular problems encountered by Native Hawaiians with diabetes. Although a variety of previous studies have outlined the prevalence of diabetes among Native Hawaiians, there is a need for further research and analysis to determine specific causal factors and refine socioeconomic and demographic data. We therefore applaud Section 3 of the bill which provides for the establishment of a program to collect data related to the prevention of diseases among Native Hawaiians and to provide for research into diseases most prevalent among Native Hawaiians, including diabetes.

Sec. 3(a)(2)(G) of the bill would provide a particularly important service to Native Hawaiians with diabetes, especially those individuals with "Type II", or non-insulin dependent, diabetes. Adherence to a strict regimen of appropriate diet and exercise is critical to the proper management of Type II diabetes; however, it appears that those Native Hawaiians with diabetes have experienced difficulty in complying with that regimen due to cultural and other factors. Therefore, training Native Hawaiians as paraprofessionals in the provision of health care and health education in Native Hawaiian communities -- particularly in the areas of nutrition, physical fitness, weight control, and prevention and control of diabetes -- would be a positive step toward removing many of the cultural, social, and behavioral barriers to effective diabetes treatment.

We also endorse the provision in S. 2243 that would allow the Secretary of HHS to provide grants to Native Hawaiian organizations to develop health promotion and disease prevention programs. Establishment of these programs at the community or local level would make them more responsive to the particular needs of Native Hawaiians. We urge the full funding of grants provided for in this section at levels recommended in the legislation.

Sec. 3(d)(1) of S. 2243 establishes a demonstration project in the State of Hawaii in an effort to meet the unique health care needs of Native Hawaiians. The project as stated in the bill would offer not only the opportunity for initiating of needed research and education programs but would also take into consideration the needs of the Native Hawaiian community by mandating the establishment of cooperative relationships with its leadership.

We also endorse the des.gnation of Native Hawaiians as a medically underserved population under Section 330 of the Public Health Service Act and the designation of Native Hawaiians as a population group that has a health manpower shortage.

For a variety of reasons it appears that Native Hawaiians do not seek treatment for a disease or affliction until the symptoms of the disease become manifest. When the symptoms or complications of diabetes become apparent, it is often too late to treat the disease effectively

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or treatment becomes difficult. If Native Hawaiians were made cognizant of the availability and importance of health care services, early detection of diabetes and other diseases would make treatment simpler and the management of complications easier. The provisions of Section 5 of the legislation regarding the establishment and operation of health care referral services for Native Hawaiians would greatly facilitate such early detection and might serve to foster a heightened awareness of the need for continual monitoring and fitness by Native Hawaiians.

Summary

The American Diabetes Association applauds the Select Committee for the leadership role it has taken in addressing the health care needs of Native Americans and we commend Senator Inouye for introducing S. 2243, which appears to be an important first step toward relieving the acute needs of Native Hawaiians with diabetes. This legislation would provide a comprehensive attack on the complications and suffering experienced by Native Hawaiians with diabetes.

PREPARED STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Mr. Chairman and Members of the Committee, the American Psychiatric Association, a medical specialty society representing over 32,000 psychiatrists nationwide, appreciates the opportunity to submit comments for the hearing record regarding S. 2243, a bill introduced by Senator Daniel K. Inouye of Hawaii to improve the health status of Native Hawaiians.

Before addressing the specific merits of S. 2243, we would like to first discuss what we feel are some of the most compelling arguments in favor of the need for such specifically targetted legislation; arguments that were brought out in the recently completed "E Ola Mau" Native Hawaiian Health Needs Study, Mental Health Task Force Report, conducted at the request of Senator Inouye by the Native Hawaiian Health Research Consortium (including Nadeen N. Andrade, M.D., Chief Psychiatry Resident at the University of Hawaii, John A. Burns School of Medicine, and a member of the APA). The study found that statistically, although they constitute only 12% to 18% of the state's population, Hawaii Natives have higher proportions of alcohol and drug abuse; higher rates of suicide and neglect; higher proportions of social problems with family, people, and children, including higher proportions of assaultive acts and antisocial behavior; higher rates of residence in correctional institutions, and higher levels of stress as indexed by leading stress markers including poverty, educational level, single family households, dwelling density, etc. Despite such a high propensity toward mental health problems, however, the study also found that Native Hawaiians seriously under-utilize available mental health services because they are unacceptable as presently structured and delivered in Hawaii. The primary reason for such under-utilization is that presently available services fail to adequately accomodate Native Hawaiian culture, including its values and life styles.

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Not surprisingly, the same problem is found among American Indians and Alaska Natives. Each group suffers from higher than average mental health problems, including alcohol and drug abuse, and high rates of suicide. All are native groups, indigenous to the areas in which they live, who were virtually invaded in their own land by the "white man," and were forced to adapt to a culture and a lifestyle very foreign to them. The APA has been very active in trying to convince Congress of the need for the federal government to provide adequate funding for health programs directed toward the special needs of this population. We should certainly do no less for Native Hawaiians.

The E Ola Mau study found that in the current delivery of health services to Native Hawaiians there is very little use of Hawaiian beliefs to describe problems, little awareness of Hawaiian cultural beliefs and practices regarding health, little use of Hawaiian language terms in health care, and little use of Hawaiian values and norms as treatment goals. According to the study, not only is there virtually no training in Hawaiian culture provided to mental health care workers, there are very few Native Hawaiian health professionals. For example, Dr. Andrade, the Native Hawaiian psychiatrist mentioned above, is reportedly one of only three Native Hawaiian psychiatrists in the entire state. With such a cultural disparity and an intense need for mental health services, we find this to be a particularly tragic statistic.

The study developed two sets of recommendations for dealing with the problem: program recommendations and research recommendations. All of them are excellent and should be invaluable to the health care professionals in Hawaii in improving their methods of treating Native hawaiians. Regarding the training of mental health professionals in dealing with the identified

problems, however, we believe the following recommendations are particularly useful:

- The development of autonomous mental health services which are community based and controlled by Native Hawaiians and which are committed to Hawaiian culture, history and language;

- The development of educational training programs within the school system and within higher education institutions to facilitate an increase in the number of Native Hawaiian mental health professionals;

- The implementation of cultural sensitivity and awareness programs under continuing education program auspices for mental health service providers, and requirements for certification of professional competence for dealing with Native Hawaiians.

Important research recommendations include:

- Conduct studies of mental health service delivery options and preferences;

- Conduct translation studies of Hawaiian language materials which involve mental health beliefs and practices;

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- Conduct studies of ethnocultural identity and develop measures of alternative life styles and their impact on health practices and outcomes.

We believe that S. 2243, which was drafted by Senator Inouye in response to the findings of the E Ola Mau study, represents an important first step in recognizing and solving some of the heretofore little understood but obviously quite extensive mental health problems of Hawaii Natives, and we strongly support its concept and its intent. Of particular interest to the American Psychiatric Association is Section 5, which provides a health service scholarship program to provide scholarship assistance to students who either meet the requirements of Section 338A(b) of the Public Health Service Act, or are Native Hawaiians.

Clearly a major reason for the woefully inadequate supply of Native Hawaiian mental health care professionals is their inability to pay for such education. Nowhere is the need greater than in the area of physician training. According to Dr. Andrade, not only are there only 3 Native Hawaiian psychiatrists; there is a total of only 18 Native Hawaiian physicians in the entire state. This provision will go a long way toward helping those who need effective mental health services, and we would hope that a particular emphasis in awarding such scholarships will be in the training of psychiatrists. This provision will also give those who qualify for such assistance a new sense of pride in being able to help their own people.

Section 6 is also a particularly worthwhile provision because it not only calls for further research into the unique problems of Native Hawaiians, but provides for a system that will help to identify ways in which to improve health services within the existing structure, and to educate health care professionals and patients alike about those available health services.

Mr. Chairman, based on what we have learned from our own member psychiatrists in Hawaii, and from the E Ola Mau report, we very much support the intent of this legislation, and we believe it will inevitably have a positive impact in dealing with the unique health care needs of Native Hawaiians.

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PREPARED STATEMENT OF AL AUBERTIN, CHAIRMAN, COLVILLE BUSINESS COUNCIL

Mr. Chairman, thank you for the opportunity to comment on S.2243, a bill to improve the health status of Native Hawaiians.

We are pleased to observe the Committee's interest in improving the health and saving the lives of the Native peoples in the great State of Hawaii. The legislation recognizes that "the Federal government retains the legal responsibility to enforce the administration of a public trust responsibility for Native Hawaiians by the State of Hawaii". This, of course, we applaud.

To Native Americans to whom the United States owes a Federal, rather than a State, trust obligation, the Colville Confederated Tribes urge your committee to focus its concerns on reauthorization of the Indian Health Care Improvement Act.

The condition of health care in this land of the first Americans must remain the Committee's first priority. American Indian tribes have the lowest health status among the ethnic populations of the United States.

When the Committee considers S.2243 to improve the health care of another needy population, we hope it will keep in mind the priority that should be accorded the trust responsibility to Indian tribes and reauthorization of the Indian Health Care Improvement Act.

May 6, 1986

PREPARED STATEMENT OF FRANK F. FASI, MAYOR, CITY AND COUNTY OF HONOLULU

CHAIRMAN ANDREWS AND MEMBERS OF THE SELECT COMMITTEE:

I am submitting to you this written testimony on behalf of the City and County of Honolulu in support of S.2243, a bill to improve the health status of Native Hawaiians.

Studies conducted at the request of the U.S. Senate by the Native Hawaiian Health Research Consortium have shown that the Native Hawaiians have for the most part far more severe health problems than any other groups. It is sad to note that the Native Hawaiians have the highest cancer rate of any ethnic group in the United States. Also, they have the highest rate of infant mortality rate from all causes. These studies also indicate that they have the most deaths from heart disease, cancer and diabetes; and have the highest incidence of chronic diseases, such as heart diseases, high blood pressure, diabetes, emphysema, etc. Native Hawaiians also have the lowest life expectancy at birth among all ethnic groups. To make the matter worse, they have the lowest income, the biggest families and the least access to health care.

It is in view of this grim picture of the health status of the Native Hawaiians as revealed by these research findings that I urge your full support for the passage of S.2243.

The key provisions of S.2243 , which include the establishment of program for health promotion and disease prevention, the establishment of community health centers, provision of health care referral services and so forth will go a long way towards improving the health status of the Native Hawaiians.

Thank you for the opportunity to testify on this matter.

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NATIONAL CONGRESS OF AMERICAN INDIANS

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May 9, 1986

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PREPARED STATEMENT OF SUZAN S. HARJO, EXCUTIVE DIRECTOR

Senator Mark Andrews
Chairman
Senate Select Committee on Indian Affairs
838 Hart Building
Washington, D.C. 20510

Dear Senator Andrews:

On behalf of the National Congress of American Indians, the oldest and largest membership organization representing American Indian and Alaska Native governments and peoples, I would like to express our support for S. 2243, legislation designed to improve the health status of Native Hawaiian people.

Native Hawaiian people are Native Americans and have been referred to as such, along with American Indian and Alaska Native people, in recent acts such as the American Indian Religious Freedom Act of 1978. The Hawaiian Nation has a treaty relationship with the United States and, like all Native American peoples, have had these treaty rights violated and have been subjected to infringement on cultural and religious practices, expatriation of lands and natural resources and the imposition of foreign systems of government. The result of this treatment is a lack of political and economic power, low educational attainment and poor health status. All Native American populations suffer from rampant alcoholism, diabetes, heart disease cancer and high infant mortality.

We agree with the approach of S. 2243, which would fund Native Hawaiian health initiatives through the Public Health Service, as opposed to the Indian Health Service which provides health programs to tribes. This separate funding mechanism will provide needed assistance without burdening the already overtaxed Indian Health Service delivery system, and will preserve the distinction between the federal government's relationship with American Indian governments and its

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relationship with Native Hawaiian people until the latter relationship is clarified by Congress and the courts.

We welcome this attention to Native Hawaiian health problems, and are pleased to support the Native Hawaiian Health Care Act. Enclosed is a resolution passed by the National Congress of American Indians in support of Native Hawaiian efforts to gain 1) Congressional acknowledgment of the wrongs committed by the United States Government against them, and 2) restitution for the resultant losses and damages.

Thank you for your consideration of our views and for your commitment to improve the health status of Native Hawaiian people.

Sincerely,

Suzan Shown Harjo
Executive Director

Enclosure

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Blue Shield Plan of Hawaii

HAWAII MEDICAL SERVICE ASSOCIATION

818 Keeaumoku St., Honolulu, HI 96814

P.O. Box 860, Honolulu, HI 96808

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PREPARED STATEMENT OF THE HAWAII MEDICAL SERVICE ASSOCIATION

Chairman Andrews and Committee Members:

The Hawaii Medical Service Association, known in Hawaii as HMSA, appreciates this opportunity to present our comments on S.2243, a bill to improve the health status of Native Hawaiians.

HMSA is a non-profit, member-owned organization providing health care coverage to 570,000 members or approximately 60 percent of the people in Hawaii. HMSA is also the fiscal intermediary in the administration of Medicare, Medicaid, and CHAMPUS programs in Hawaii. Additionally, HMSA plays an active role in the health of all Hawaii's people through a wide variety of community health service activities. These activities include Hawaii's largest self help, telephone health information system, community and worksite health promotion programs and participation in numerous community health fairs.

While we believe our public service activities have played an important role in raising the level of health of our community as a whole, we recognize traditional health service delivery is not necessarily appropriate for all ethnic groups in Hawaii.

Available health data indicates a continuing high prevalence of serious physical and mental health problems among our Native Hawaiian population. This data also suggests Native Hawaiians rely less on traditional health care than does the rest of the community.

S.2243 offers an alternative to the existing health delivery system through programs of health research and planning, disease prevention, health education, health service referral, and the establishment of community health centers -- all specifically designed to meet the needs of Native Hawaiians. Further, this bill acknowledges that active participation by Native Hawaiians in these Federally supported programs is an appropriate way in which to improve the health status of this segment of our community.

In conclusion, we believe programs such as these will have a distinctly positive effect upon the health of Hawaii's native population and therefore HMSA supports S.2243 and urges the Committee's favorable consideration of this bill.

Sincerely,

RALPH J. KIESSLING
Executive Vice President

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CR194/T-2

OFFICE OF THE MAYOR
4396 RICE STREET
LIHUE, KAUAI, HAWAII 96766

May 7, 1986

PREPARED STATEMENT OF TONY T. KUNIMURA, MAYOR, COUNTY OF KAUAI

Senator Mark Andrews
Chairman, and Members of the Select Committee
on Indian Affairs
UNITED STATES SENATE
Washington, D. C. 20510

Chairman Andrews and Committee Members:

I am in total support of S.2243 which is intended to improve the health status of the Native Hawaiians. I am particularly encouraged by the provisions that monies may be granted to Native Hawaiian organizations to accomplish the major objectives of the Bill.

As you might be aware, a sizeable Native Hawaiian community resides in the County of Kauai, which includes the islands of Kauai and Niihau. The latter is privately owned and is one of the last substantial enclaves of pure-blooded Hawaiians. The findings of your Bill are valid and confirmed in clinical records of the health care providers servicing this target population. In view of the continued high mortality rate of the Native Hawaiian compared to other ethnic groups in the State of Hawaii, your Bill is considered timely and essential if we are to insure the continued existence of the Native Hawaiian and improve the quality of life for these Native Americans.

You can be assured that there are Native Hawaiian and Part-Hawaiian organizations which are actively seeking financial support to address the health care needs of our Native Hawaiians. Your Bill addresses the very foundation of what I perceive to be needed, i.e. education and training to the Native Hawaiian in health promotion and disease prevention. This is no easy task in view of the Native Hawaiians' lack of acceptance of western medicine and dependence on traditional Hawaiian healing practices. It should be emphasized that behavioral changes must take place if we are to see a decrease in the rate of incidence in the major disease categories in Native Hawaiians. I feel we must integrate the traditional and acceptable Hawaiian healing practices with modern medicine to achieve any degree of success. Also, the cooperation and knowledge of our kahunas, kupunas, and other Hawaiian practitioners are essential to enhance our program efforts.

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I realize that it would be difficult to incorporate all of the above factors into the Bill, but I appreciate that you have taken this opportunity to introduce major legislation that would provide the financial resources to accomplish such an awesome task. You can be assured that I will follow the progress of this Bill very closely and pray for its success. Mahalo.

Very truly yours,

TONY T. KUNIMURA
Mayor, County of Kauai

HOU HAWAIIANS

A TRIBAL OHANA DEDICATED TO THE SURVIVAL OF THE HAWAIIAN PEOPLE
P.O. Box 1067 Kaneohe, Hawaii 96744 Phone(808) 538-3511

1986 MAY 27 PM 2:14

PREPARED STATEMENT OF MAUI LOA, CHIEF OF THE HOU

United States Senate
Select Committee on Indian Affairs
Senator Mark Andrews, chairman
Room SR838 Senator Hart Office Bldg.
Washington, D.C. 20510

May 20, 1986

Aloha Chairman Andrews and Members of the Select Committee on Indian Affairs:

For the record, as Chief of the Hou I would like to submit some comments on S.2243 or any other bills pertaining to the well-being of Native Hawaiians.

1) As the bill defines Native Hawaiians on page 6, it conflicts with the definition of Native Hawaiians in the Hawaiian Homestead and EP provisions of the Statehood Admissions Act. If the bill means to say Native Hawaiians of 50% aboriginal blood or more and their descendents of any amount of aboriginal blood, why doesn't it then let Congress and the public know this essential distinction.

2) The statistics of health problems in S.2243 reflect the condition of the few remaining Native Hawaiians of 50% aboriginal blood or more, numbering approximately 10,000 people. The budget figures in this bill however will obviously be ten times that number, since it includes anyone claiming the slightest amount of Hawaiian blood.

3) Indigenous aboriginal peoples are unquestionably badly in need of health assistance. Their health needs in S.2243, however, are being subsumed by a much larger, ever-expanding group of non-natives.

Moreover, there should also be a section in this bill for the traditional Native Hawaiian practitioners to treat their people in the Ancient ways. Like Indians, Alaskan natives, and Aleuts, Native Hawaiians should at least enjoy a small percentage of the benefits from funds allocated in their name. Common sense

dictates that some of the funds should go directly to those "Ohana", tribal bands, who specialize in taking care of the needs of the genuine Indigenous people.

Unfortunately, even though the Hou are directly responsible for 4,000 beneficiaries receiving their Homestead lands since 1983, and for the inclusion of Native Hawaiians in Native American programs, we were not consulted in helping structure this vitally important Health Bill. A difficult cross to bear when one considers it is our constituency of the blood who, because of Westernization, are sick and dying. Everything said in this bill is true. To be ethically and morally acceptable it needs a clause giving priority consideration to the genuine Native Hawaiians of 50% aboriginal blood or more.

Mahalo Nui Loa for your consideration in this matter.

Maui Loa
Chief of the Hou

ML:js
enclosure

Talking Leaf, 5/86, p.8

Traditional Indian medicine program at St. Mary's first in country

St. Mary's Hospital and Health Center was the first hospital established in the Arizona Territory in 1880. Today, "the ministry of mercy and health to all peoples" continues to expand as St. Mary's is the first non-Indian Health Service hospital in the country to incorporate a Traditional Indian Medicine program as a bi-cultural approach to healing.

"An Advanced Exploration of Traditional Indian Medicine in Today's Health System" is the title of the next conference sponsored by the hospital, scheduled for May 3-9 in Tucson.

An advanced, intensive, didactic and experiential conference, the program includes practitioners of Traditional Indian and Hawaiian Medicine and a spiritual healer.

The ninth in a continuing program of Traditional Indian Medicine, the conference will provide opportunity to experience the integration of spirit, mind, body, the environment and God.

For more information on the conference, contact St. Mary's Hospital (602) 622-5833, ext. 1452. The registration for the full conference is $175 is postmarked by March 31, $200 by April 14, and $250 after April 15. Employees of Carondelet Health Services, the Indian Health Service and Native Americans are eligible for reduction registration.

The Traditional Indian Medicine program began in May 1984 after an Indian nurse attended a workshop in Tucson that focused on holistic and spiritual aspects of health care.

It was evident immediately that the Traditional Medicine people who came to share their philosophies of life and disease were offering an understanding of the healing process that affects all people regardless of ethnicity.

Traditional Indian Medicine as practiced in the program at St. Mary's personifies holistic health, encompassing a person's physical, emotional, spiritual and environmental aspects of being as connected with the Divine Creator. Traditional Indian Medicine is embraced by the staff as an enhancement of the Catholic identity and mission of St. Mary's hospital.

The program was expanded to include development of traditional cultural opportunities for Native American patients and families and a rapidly growing focus on development of the spiritual forces in the healing process in health care.

The first traces of the Traditional Indian Medicine program's influence are already evident at St. Mary's:

Traditional Indian Medicine practitioners are openly welcome on all patient units and may choose to be escorted by a staff member who is sensitive to their protocols;

Prayer ceremonies are performed as desired;

An office has been donated at St. Mary's for the use of Traditional Medicine Practitioners to meet with patients and families before, during or after hospitalization;

A Native American translator program is being developed in Tohono O'odham (Papago) and Yaqui to offer non-English speaking Native Americans.

The National Indian Health Board has strongly endorsed St. Mary's program and advertises the educational/staff development tract to its members.

Recent conferences organized by St. Mary's have attracted more than 400 Carondelet staff members. In Phoenix in October of last year, more than 160 people from 18 states and Canada participated.

Hospitals around the United States and Canada have approached St. Mary's to organize similar conferences in their areas.

The conferences are all directed by Edgar Monetathchi Jr., a National Traditional Medicine Specialist from the Indian Health Service to Monetathchi, a Comanche Medicine Man says that traditional Indian medicine is a "philosophy of life. It encompasses the whole individual, body, mind and spirit."

A Paul Ortega, a Mescalero Apache Medicine Man and national recording artist with Canyon Records, and Al Flores, a Tohono O'odham-Cheyenne Medicine Man, appeared with Monetathchi at a conference at St. Mary's in January.

They and 15 others are scheduled to take part in the conference in May.

University of Hawaii at Manoa

School of Nursing
Office of the Dean
Webster Hall 416 • 2528 The Mall
Honolulu, Hawaii 96822

PREPARED STATEMENT OF DR. JEAN L. J. LIM, DEAN, SCHOOL OF NURSING, UNIVERSITY OF HAWAII AT MANOA

Chairman Andrews and Members of the Senate Select Committee on Indian Affairs:

The School of Nursing at the University of Hawaii at Manoa stands in full support of S. 2243, "A Bill to Improve the Health Status of Native Hawaiians, and For Other Purposes."

It has become increasingly clear that existing programs targeted toward improving the health status of Native Hawaiians have not yet fully addressed, either equitably or effectively, the magnitude and chronicity of problems faced by that indigenous population. While Native Hawaiians represent approximately 17% of the total population of the State of Hawaii, they remain disproportionately represented among groups with the highest incidence and prevalence of serious acute and chronic illness; among groups residing in rural areas with minimal access to comprehensive health services and in high-risk, low socioeconomic urban pockets; and among groups with minimal opportunity for meaningful participation at all levels of health program planning, development, and implementation.

Native Hawaiians are also acutely underrepresented in the health professions. While it has been found that Native Hawaiians utilize and would benefit from health services provided by culturally sensitive and culturally based health professionals, few avenues exist to effectively recruit, retain, and graduate Native Hawaiians who would function as practitioners within their own communities. The School of Nursing initiated such a program in 1984. Funded through a Special Nursing Projects Grant from the Division of Nursing, U.S.D.H.H.S., the Special Nursing Opportunities Program has made significant strides toward increasing the enrollment of academically and financially disadvantaged Native Hawaiian students. While Native Hawaiians once composed less than 9% of all students who undertake undergraduate professional nurse training at the School of Nursing, their number has almost tripled. The special program has not only facilitated the entry of such students into the School of Nursing, but has also provided intensive academic remediation, personal and academic retention services, and financial assistance.

With the implementation of the Gramm-Rudman-Hollings balanced federal budget act before us, we are extremely concerned that efforts be made to continue health professional education programs which aid in the retention and graduation of indigenous practitioners. We are particularly gratified to note that S. 2243 provides for scholarship assistance to Native Hawaiian students who would not otherwise be able to incur the cost of higher education in Hawaii. Financial

assistance alone, however, will not act singly to encourage or enable the enrollment of such students in highly competitive health professional schools. Continued emphasis also needs to be given to the areas of pre-professional academic preparation and the provision of effective retention services which Native Hawaiian students are enrolled in health professional training.

The options available to Native Hawaiians that promote health and minimize illness can most effectively be provided through broad public policy reflecting the need to prepare indigenous professionals who in turn provide cost-effective health care services. This could reverse the trend of the chronicity of problems now prevalent in the Native Hawaiian population. We therefore urge the passage of S. 2243.

Prepared Statement Of Anthony J. Marsella
Acting Vice President for Academic Affairs
University of Hawaii at Manoa
Honolulu, Hawaii

Chairman Andrews and members of the Select Committee on Indian Affairs. Thank you for providing me with the opportunity to give testimony in support of S.2243, a bill to improve the health status of Native Hawaiians.

I speak in favor of this bill from two different perspectives. The first is as the Chair for the Mental Health Task Force of the E OLA MAU: Native Hawaiian Health Needs Study. The second is as the Acting Vice President for Academic Affairs at the Univeristy of Hawaii at Manoa. My comments will be brief and will speak to the general intent of this bill. Others will speak in more detail on the health needs of Native Hawaiians and to the particular merits of this bill.

The E OLA MAU study was a project sponsored by the Department of Health and Human Services, Region IX through the auspices of ALU LIKE, Inc., a Native Hawaiian community organization. The study was completed in December 1985. This study found Native Hawaiians at risk for a number of health and mental health problems which is a finding made by others before us. A unique feature of this study, however, was its finding that a number of social, economic, and political factors contributed to the negative health status of Native Hawaiians. The study concluded that federal and state institutions have the responsibility to insure that changes take place which can facilitate the empowerment of the Native Hawaiian community.

While this bill does not specifically address the issue of the empowerment of Native Hawaiians, it does recognize that need for the Native Hawaiian community to be involved in the development and implementation of health programs and research. This is a critical part of this bill. In the past, Native Hawaiians have seen health programs initiated which did not provide appropriate services which met their needs. Too often, Native Hawaiians have seen health research conducted in their communities and have not benefited from them.

This bill is a positive step in resolving some of the pressing health concerns faced by Native Hawaiians. But it is only one step. Institutions at all levels must share in your effort to bring about social, economic, and political changes to insure long lasting improvement of Native Hawaiian health.

As Acting Vice President for Academic Affairs at the University of Hawaii, I share with you the University of Hawaii's commitment to assist the Native Hawaiian community when called upon. A number of professors participated in the E OLA MAU Study and have continued to provide technical assistance in many areas. The University of Hawaii remains ready to work with the Native Hawaiian community in order that appropriate health programs and research result from this important bill.

Thank you again for the opportunity to provide testimony in favor of S.2243.

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University of Hawaii at Manoa

1986 MAY -7 AM 10:2?

School of Public Health
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PREPARED STATEMENT OF JERROLD M. MICHAEL, SC.D., DR.P.H.

DEAN AND PROFESSOR OF PUBLIC HEALTH

Senator Mark Andrews
Chairman
Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

In response to your letter of April 17, 1986, I am indeed pleased to submit this testimony on behalf of the School of Public Health in relation to the Select Committee on Indian Affairs review of S. 2243, a bill to improve the health status of native Hawaiians.

This faculty is in total agreement with the assessment of special need for native Hawaiians described in Section 1 of the bill. Many of our faculty have in fact made substantial contributions to the development of the data base for those statements. The profile of the health status and needs of native Hawaiians is one that properly requires addressing. This has been a prime interest of your colleague and our good friend, Senator Daniel K. Inouye.

Native Hawaiians are among those groups in the United States at the highest risk for a broad spectrum of health problems. Diabetes, heart disease, cancer, and hypertension are illustrative examples. We are anxious to assist in providing input into a comprehensive public health approach to not only prevent disease, but to promote health through the establishment of accessible and culturally appropriate health services. That can best be done through programs which promote self care and lifestyle change and through the establishment of healthier environments.

Of special need are programs in the area of pre- and post-natal infant health care as well as maternal health care. This bill encompasses such a comprehensive view and provides an appropriate approach to the unique needs of native Hawaiians.

We are especially pleased to see the commitment that this bill makes in the area of research, addressing the health needs and status of the native Hawaiian population. Our faculty has a commitment to continue contributing to a deeper understanding of these needs through epidemiological surveys in cancer and hypertension control, improved mental health, drug and alcohol programming, and the elimination of the problem of dental caries. We look forward to continuing as a contributing partner in these research efforts.

AN EQUAL OPPORTUNITY EMPLOYER

Of special importance to our State is the content of the bill strengthening scholarship assistance to native Hawaiian students. Since 1978, the School of Public Health has offered programs for "disadvantaged" students including American Indians, Alaska Natives, Pacific Islanders, and of course native Hawaiians. We are committed to the education of native Hawaiian professionals so that they can serve as an important core of workers who can improve the health status of their own people. This underscores the notion that the key to improving the health status of native Hawaiians is the development of indigenous health professionals.

I am also pleased to note that this bill provides for the establishment of a three-year demonstration project to meet the unique health needs of native Hawaiians. We would like to see the demonstration project include not only health care in the conventional sense, but also traditional approaches to health promotion focusing on the establishment of healthy environments in the school, workplace, and other community settings--which especially impact on children and the elderly.

As Senator Inouye may have advised you, the University of Hawaii's School of Public Health serves Hawaii and the Pacific region as an International Center for Health Promotion and Disease Prevention. We have an abiding commitment to the needs of the special populations in that region. We see the passage of this bill as complementing and strengthening the ongoing efforts of the University to address the native Hawaiian community's capacity to be integrally involved in assessing its own health needs. That suggests a partnership for health enhancement.

With all of the above in mind and on behalf of the faculty of the School of Public Health, I urge the Select Committee on Indian Affairs to pass S. 2243 so it can serve as a vehicle for us all to better fulfill our challenge to improve the health status of native Hawaiians to the highest possible level and to encourage maximum participation of native Hawaiians in the planning and management of their own health services.

I thank you for the opportunity to submit testimony regarding this most worthy bill.

Aloha,

Jerrold M. Michael

Jerrold M. Michael, Sc.D., Dr.P.H.
Dean and Professor of Public Health

DRAFT CONGRESSIONAL BUDGET OFFICE ESTIMATE OF COSTS ASSOCIATED WITH S. 2243

DRAFT

(By fiscal year, in millions of dollars)

	1987	1988	1989	1990	1991
Estimated Authorization Levels					
Management Grants	0.6	0.6	0.6	0.6	0.6
Demonstration Project	--	0.5	0.5	0.5	--
Scholarships	1.8	1.8	1.8	1.8	1.8
Health Care Referral	0.6	0.6	0.6	0.6	0.6
Planning Grants	0.8	0.8	0.9	0.9	1.0
Community Health Centers	2.8	3.0	3.1	3.3	3.5
HPDP Program	9.4	9.6	9.9	10.5	11.3
Education	0.3	0.3	0.3	0.4	0.4
Study	0.3	--	--	--	--
Total Estimated Authorization Level	16.6	17.2	17.7	18.6	19.2
Total Estimated Outlays	9.4	14.8	16.9	18.1	18.8

	1987	1988	1989	1990	1991
Breakdown of HPDP Program Costs					
Data Collection	2.0	2.1	2.1	2.2	2.4
Research	0.5	0.5	0.5	0.5	0.6
Education	0.3	0.3	0.3	0.4	0.4
Health Planning	1.2	1.3	1.3	1.4	1.5
Outreach Workers	5.0	5.3	5.6	5.9	6.3
Training	0.4	0.1	0.1	0.1	0.1
Total HPDP Program	9.4	9.6	9.9	10.5	11.3

Prepared Statement Of

Georgiana K. Padeken
Chairman, Hawaiian Home Commission
Honolulu, Hawaii 96813

Honorable Chairman and members of the Committee, aloha. My name is Georgiana K. Padeken, Chairman of the Hawaiian Homes Commission, the executive board of the Department of Hawaiian Home Lands.

The Commission administers lands set aside by Congress in 1920 under the Hawaiian Homes Commission Act for purposes relating to rehabilitation of native Hawaiians. Two architects of the Act were Mr. John Wise, a respected Hawaiian leader and territorial legislator, and Prince Jonah Kuhio Kalaniana'ole, Hawaii's delegate to Congress in the early territorial years. Both men were deeply concerned about the failing health and decreasing population of native Hawaiians in Hawaii, their own homeland. In testifying before the House Committee on Territories, 66th Congress, Mr. Wise eloquently described the Prince's and his concern:

> The Hawaiian people are a dying people. Just at a time the American people are trying to do something for the dying people of Europe. They are reaching out across the Atlantic and are trying to help the Belgians, to help the French, and to help other races in Europe, and I would like to have the Committee just pause for a moment and look back at the Hawaiians.....a noble race.

Two former Hawaiian kings in earlier days had expressed their concern for what was happening to their people. On April 7, 1855, in his remarks before the opening of the kingdom's legislature, Kamehameha IV passionately related:

> A subject of deeper importance, in my opinion, than any I have hitherto mentioned is that of the decrease of our (native Hawaiian) population. It is a subject, in comparison with, which all others sink into insignificance; for, our first and great duty is that of self-preservation. Our acts are in vain unless we can stay the wasting hand that is destroying our people. I feel a heavy, and special responsibility resting upon me in this matter; but it is one in which you all must share; nor shall we be acquitted by man, or our Maker, of a neglect of duty, if we fail to act speedily and effectively in the cause of those who are everyday dying before our eyes.

More than thirty years later, in 1887, King Kalakaua prophetically wrote in his Legends and Myths of Hawaii:

> Year by year their (native Hawaiian) footprints will grow more dim along the sands of their reef--sheltered shores, and fainter and fainter will come their simple songs from the shadows of the palms, until finally their voices will be heard no more forever.

It has been in the spirit of Kuhio, Wise, Kamehameha, and Kalakaua that the Department of Hawaiian Home Lands has participated as a member of the Native Hawaiian Health Consortium convened in 1985 by Alu Like. Data from its recently completed report on the status of native Hawaiian health in the State makes it clear that native Hawaiians have not recovered from the impacts of the 19th Century and that their quality of life, generally, is not at the level enjoyed by other ethnic groups in the State.

The Hawaiian Homes Commission views Senate Bill 2243 as a means to begin addressing some of the concerns identified in the Consortium's report and to begin improving the health status of native Hawaiians. It strongly supports passage of the bill.

Rehebilitation, in its truest sense, is defined as "restoring to a former condition." The various provisions of S.B.2243 will begin to address native Hawaiians health needs.

Section 3 on Health Promotion and Disease Prevention will provide resources to begin addressing more serious health issues of native Hawaiians.

Section 4 relating to community health centers will provide for Comprehensive Health Care approaches to problems of isolation and non-accessible services.

Section 5 on scholarship programs will allow native Hawaiian youths to better participate in health professions and professional training.

Section 6 on referal services will provide an opportunity for native Hawaiian groups and organizations to become involved in health-related issues and concerns of their people and to begin addressing these concerns themselves.

Section 7 on access to medicare and medicaid will begin to address the plight of many elderly native Hawaiians who are not able to obtain adequate health care.

These provisions, together, form a comprehensive approach to addressing native Hawaiian health. They are in concert with recent policies emerging from the U.S. Surgeon General's Office and, indeed, are consistent with the prevailing mood of the nation.

The Department of Hawaiian Home Home Lands has more than 4,000 residential, farming, and ranching homestead leases on the islands of Oahu, Maui, Hawaii, Kauai, and Molokai. These homesteads are clustered in 14 communities composed of native Hawaiians (one-half or more Hawaiian ancestry) and their families. Many of these communities are located in rural areas where the level of health services available is not adequate. This bill can provide mechanisms to address native Hawaiian homestead health needs and to extend appropriate health services to these communities.

On behalf of the Hawaiian Homes Commission, I want to thank the members of the U.S. Senate Select Committee on Indian Affairs for providing us with the opportunity to comment on this bill.

University of Hawaii at Manoa

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International Center for Health Promotion and Disease Prevention
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PREPARED STATEMENT OF JONATHAN S. RAYMOND, PH.D., ASSOCIATE PROFESSOR

Senator Mark Andrews, Chairman
United States Senate
Select Committee on Indian Affairs
Washington, DC 20510

Dear Senator Andrews:

Re: Senate Bill 2243

I am pleased to submit written testimony endorsing the spirit and substance of Senate Bill 2243. The comprehensive scope of needs for better health is nowhere more compelling in a group of American citizens than among Native Hawaiians. The profile of significant need is well-established and clear.

This Bill provides an opportunity to achieve much for Native Hawaiians and for other Polynesian groups in Hawaii and throughout the American Pacific. The experience and knowledge to be gained by the passage and implementation of S. 2243 bodes well for the development of services and programs and the conduct of research which will no doubt generalize in its implication and relevance throughout the Pacific.

I am also confident that the initiatives established by S. 2243 will likewise provide insights which are beneficial to the forward movement of health promotion and disease prevention programs across the country as well.

While others, no doubt, will testify more straightforwardly about the health benefits to Hawaii and to Native Hawaiians to be occasioned by the Bill's passage, I wish to highlight the broader impact of the Bill on the nation's health. This topic has captured and held the interest and commitment of both the academic and community sectors. There is, therefore, a positive coming together of academic and community resources in Hawaii in which a great deal of health-related knowledge and wisdom is being acquired through this initiative. The further acquisition and dissemination of the knowledge on Native Hawaiian health and the establishment of responsive programs and services through

Senate Bill 2243 will benefit Native Hawaiians and other Pacific Islands populations as well. Moreover, passage of the Bill will benefit the nation's health as new approaches, methods, and innovations are adopted and developed here in Hawaii and shared with our mainland counterparts.

I know the academic community in Hawaii, especially those of us who serve in the health and social sciences, remains committed to this work. We welcome the positive action of Congress not only on behalf of Native Hawaiians, but on behalf of the nation as well.

Aloha and Pono Maikai (Good Health),

Jonathan S. Raymond

Jonathan S. Raymond, Ph.D.
Associate Professor
DIRECTOR

Hawaii Public Health Association
Past President

JSR:sc

cc: Senator Daniel Inouye

United States Department of the Interior

OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20240

PREPARED STATEMENT OF ROSS O. SWIMMER, ASSISTANT SECRETARY

Honorable Mark Andrews
Chairman, Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This responds to your request for our views on S. 2260, a bill "To settle certain claims arising out of activities on the Pine Ridge Indian Reservation."

We oppose enactment of S. 2260.

S. 2260 is essentially a private relief bill. The bill would compensate 113 individuals and businesses (who were plaintiffs in a prior legal action) for amounts ranging from $731 to $490,934 each for personal injuries or damages to their property during the occupation of Wounded Knee, South Dakota, which occurred between February 27, 1973, and May 8, 1973. S. 2260 would also provide $26,486.44 to the Dakota Plains Legal Services, formerly South Dakota Legal Services Corporation, for services provided.

The claimants have disavowed any claim based on a legal right of recovery and instead attempted to build a case in support of a claim for purely equitable relief. The time periods involved in their claims began with the incidents leading up to and including the November 4, 1972, takeover of the Bureau of Indian Affairs (BIA) building in Washington, D.C., and continued through the occupation of Wounded Knee, South Dakota, in early 1973. The claimants have contended that the United States actions, or failures to act, were responsible for the damages and losses suffered by them as a result of the Wounded Knee occupation.

The United States Court of Claims completed a thorough investigation and analysis of the claims made by the claimants. The Court of Claims report entitled "The Innocent Victims of the Occupation of Wounded Knee, South Dakota v. The United States (Cong. Ref. 4-76), Findings of Fact and Recommended Conclusions to Accompany the Opinion of the Trial Commission filed June 10, 1981" concluded:

> The above ultimate conclusions remove the predicates necessary for plaintiffs to have any basis for equitable claims against the United States. While it is true that plaintiffs did incur property damages and losses as a result of the occupation of Wounded Knee by militant forces of AIM [American Indian Movement], the United States should not be deemed legally and/or equitably liable for said damages since its reaction and response to the occupation was prompt, reasonable and honorable. Expert testimony indicated that the government's

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conduct in terminating the Wounded Knee occupation comported most favorably with present-day accepted and recognized standards, policies, practices and procedures utilized in handling hostage and barricade situations. Under such circumstances, any monetary award to plaintiffs for damages arising out of the Wounded Knee occupation would be a gratuity.

Although the Court of Claims has determined that the monetary damages suffered by the claimants amounted to about $1,600,000, the findings referenced above indicate that compensation from the Federal Government is not appropriate in this case.

The Office of Management and Budget has advised that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

ASSISTANT SECRETARY ROSS O. SWIMMER

Prepared Statement Of

The Waianae Coast Comprehensive Health Center

The Waianae Coast Comprehensive Health Center (WCCHC) is the largest provider of primary medical care serving a predominantly Hawaiian/Part Hawaiian patient population. The Health Center has approximately 14,000 currently registered patients generating 60,000 patient visits a year. Two-thirds of the Health Center's patients are Native Hawaiians/Part-Hawaiians.

The WCCHC appreciates the opportunity to strongly endorse Senate Bill 2243. We believe this legislation is particularly innovative for the following reasons:

1. S. 2243 maximizes the use of existing channels of federal funding rather than establishing new bureaucracy.

2. S. 2243 establishes a systematic approach to developing community-based interventions, decentralizing funding opportunities, and integrating public and private resources.

3. S. 2243 takes advantage of the quality assurance and administrative monitoring regulations of the community health center program (PHS 330) which was recently reauthorized by Congress with strong bipartisan support.

4. S. 2243 includes an appropriate complement of strategies including education, clinical services, training and research.

5. S. 2243 has the endorsement of a broad base of Hawaiian community leaders who have been given opportunity to participate in its development.

The Native Hawaiian Health Needs Study, recently submitted to the U. S. Public Health Service, has documented the extensive health care problems facing the Hawaiian people. Senate Bill 2243 recognizes these conditions and places the health needs of Native Hawaiians on par with those of our country's other indigenous peoples. In light of federal funding restraints, it does so efficiently with a comparatively low per capita allocation.

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Prepared Statement Of

G. Analika Nahulu Victor
Community Specialist, Alu Like, Inc., O'ahu Island Center
Honolulu, Hawai'i

My name is G. Analika Nahulu Victor and I am a Native Hawaiian (Public Law 96-565, title 1, the Native Hawaiians Study Commission) and a member of E Ola Mau, the permanent and only Native Hawaiian organization of Hawaiian Health Professionals.

I support Senate Bill 2243, a proposal to improve the health status of Native Hawaiians, and will address Section 6 on Health Care Referral Services.

Over the past 10 years, I have served communities whose residents are predominantly Native Hawaiian (Public Law 86-3, section 4, Hawaiian Homes Commission Act, 1920 as amended) through a variety of health education programs. A large number of this class of Native Hawaiians reside on lands designated for the purpose of the "betterment of conditions of Native Hawaiians" under a homesteading program.

Irregular, non-standardized collection and recording of health data, varying definitions of Hawaiian, Part-Hawaiian, and Native Hawaiian contribute to the lack of a systematic study of Native Hawaiian health needs. It is the Native Hawaiian who must impact the success of the health programs by demonstrating preventive health practices.

A system of health care services cognizant of beliefs and practices

effective for promoting wellness, controlling and preventing illness insures the raising of the health status of Native Hawaiians. A system that promotes cultural sensitivity ought to encourage a population undergoing Western industrialization, to participate in the planning and management of this changing process. Examples of this participation would be in developing appropriate training and health promotion for disease prevention, in identifying and utilizing health service resources, in developing non-existing resources that are appropriate to the Native Hawaiian and in the establishment of health manpower training programs that focus on developing Native Hawaiian community health educators.

The design of this system of health care services is that the operation is developed by local health care personnel who are sensitive and responsive, and is controlled by local organizations for the greatest amount of impact on health conditions.

I thank you for this opportunity to provide testimony on this measure to improve the health status of Native Hawaiians.

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NATIONAL INDIAN HEALTH BOARD, INC.
"Today's Youth — Tomorrow's Elders."
A Commitment to a Healthier Nation"

1988 MAY 15 AM 10 16

PREPARED STATEMENT OF JAKE L. WHITECROW, EXECUTIVE DIRECTOR

The Honorable Mark Andrews
Chairman
Senate Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

Thank you for providing the National Indian Health Board an opportunity to comment on S. 2243, a bill to improve the health care status of Native Hawaiians. I regret that our Board of Directors has not had the opportunity to fully review this important bill--we will take a formal position on S. 2243 at the Board's next meeting. However, based upon comments we have received to date we wish to make the following brief observations about the bill.

Itwould be inappropriate to draw any direct parallels between Indians and Native Hawaiians with regard to legal and political status, since the provision of health care services to Indian people is predicated upon the unique historical and trust relationship that Indian Tribal governments have with the United States government. However, many American Indians and Alaska Natives can no doubt sympathize with the plight of Native Hawaiians who, like our people, had their lands illegally taken from them, had their culture and their Native way of life destroyed, and must now endure inadequate health and living conditions.

As it is our understanding that programs authorized by S. 2243 will in no way impact the Indian Health Service or federal appropriations for Indian health care, and representatives from the Native Hawaiian community have clearly stated that it is not their intent to have Native Hawaiians included as part of the IHS service population, I believe the American Indian and Alaska Native community would not oppose enactment of this legislation.

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Concern about the inclusion of Native Hawaiians in the Indian service population is partially based on provisions within other pending Indian health-related bills (e.g., S. 277, the Indian Health Care Amendments of 1985; and S. 1988, the Native American Diabetes and Control Act of 1985) that would specifically extend to Native Hawaiians certain services provided by the Indian Health Service. As noted in our testimony on S. 1988, we believe such provisions would be more appropriately included in separate legislation addressing the larger issue of Native Hawaiian health care, and S. 2243 would be an excellent legislative vehicle for this purpose.

We therefore request that the Committee consider deleting existing provisions related to Native Hawaiians in S. 277 and S. 1988, and include those provisions in S. 2243. We also ask that the Committee consider report language prohibiting the Department from administering any of these new Native Hawaiian health programs through the Indian Health Service, and specifying that funding for Native Hawaiian health programs shall not adversely affect appropriations that would otherwise be available for the provision of health care services to American Indians and Alaska Natives.

Nothing in our recommendations should be taken as a lack of support for the efforts to improve the health conditions of Native Hawaiians. As reported in the "Native Hawaiian Health Needs Study" (December, 1985), the Native people of Hawaii suffer a much poorer health status than other populations of the state: infant mortality rates among Native Hawaiians are higher than the national average; Native Hawaiians have been shown to have higher rates of health disease, hypertension, diabetes, cancer, and other health problems than do other populations in the state of Hawaii; housing and sanitation facilities for many Native Hawaiians are substandard; and medical and health services are often either unobtainable or cannot be afforded by many Native Hawaiians. Indeed, it appears that Native Hawaiian communities experience many of the same deplorable health conditions we find on many Indian reservations, and we strongly support efforts to rectify these deficiencies.

Furthermore, many of the problems faced by Native Hawaiians are directly attributable to the actions and policies of the Federal government. As a result of the illegal overthrow of the Hawaiian monarchy and seizure of Hawaiian lands at the turn of the century, Native Hawaiians have lost their traditional government and much of their Native culture and way of life. Past

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Federal efforts to assist Native Hawaiians, such as enactment of the Hawaiian Homes Commission Act of 1921, have established a public trust responsibility on the part of the United States government to work toward the betterment of the Native Hawaiian people. Enactment of S. 2243 would be an important step in the fulfillment of the trust responsibility.

In recognition of the dire health care needs of Native Hawaiians and the Federal government's commitment to the Native Hawaiian people, I believe S. 2243 should be supported and urge that the Committee give the bill favorable consideration. I believe that the S. 2243 sets the proper tone and direction needed to carry out the objectives of improving the health status of Native Hawaiians, particularly with its emphasis on prevention and health promotion.

I am also disappointed to hear of the Administration's opposition to S. 2243 on the grounds that authority to provide these much-needed programs is already available. Over the past few years, we have become all too familiar with similar rhetoric from the Administration directed at legislation designed to improve the delivery of health care services to American Indians and Alaska Natives. If the Administration's past record with regard to Indian health is any indication, you can be assured that virtually nothing will be done to meet the health care needs of the Native Hawaiian people unless the Congress specifically directs that such action be taken.

Again, Senator Andrews, thank you for the opportunity to comment on S. 2243. I would be happy to respond to any further questions regarding this important matter.

Sincerely,

Jake L. Whitecrow

Jake L. Whitecrow
Executive Director

RESOLUTION 48-85-GA

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Lumbee

RESOLUTION SUPPORTING THE HAWAIIAN NATIVES IN THEIR QUEST FOR CONGRESSIONAL ACKNOWLEDGMENT OF ILLEGAL AND IMMORAL ACTIONS OF THE U.S. IN THE OVERTHROW OF THE KINGDOM OF HAWAII IN 1893, TOGETHER WITH RESTITUTION FOR LOSSES AND DAMAGES RESULTING FROM WRONGFUL ACTIONS

WHEREAS, THE STATE OF HAWAII AND ALL OF HER PEOPLE PROUDLY SHARE, ENDORSE, AND ENCOURAGE AMERICAN IDEALS AND PRINCIPLES OF JUSTICE THROUGH LAW, AND PROFOUNDLY BELIEVE THAT AN UNRESOLVED INJUSTICE TO ONE IS A HARM ENDURED BY ALL; AND,

WHEREAS, SUCH A HARM TO NATIVE HAWAIIANS HAS OCCURRED WITHOUT REDRESS OR REMEDY; AND,

WHEREAS, NATIVE HAWAIIANS HAVE BEEN INCLUDED AND IDENTIFIED AS NATIVE AMERICANS IN RECOGNITION OF THEIR UNIQUE AND SPECIAL RELATIONSHIP WITH THE UNITED STATES AS AN INDIGENOUS PEOPLE; AND,

WHEREAS, AS A RESULT OF THE GOOD CONSCIENCE OF THE AMERICAN PEOPLE, SPEAKING THROUGH THE CONGRESS, REDRESS AND REMEDY HAVE BEEN GRANTED TO OTHER NATIVE AMERICANS FOR INJUSTICES AND HARM DONE THEM; AND,

WHEREAS, THE CONGRESS OF THE UNITED STATES HAS INDICATED ITS INTEREST IN THE PURSUIT OF SEEKING RESOLUTION TO POSSIBLE CLAIMS BY NATIVE HAWAIIANS FOR THE LOSSES AND DAMAGES WHICH RESULTED FROM THE OVERTHROW OF THE LEGAL GOVERNMENT OF THE KINGDOM OF HAWAII IN 1893; AND,

WHEREAS, THE CONGRESS ENACTED PUBLIC LAW 96-565, TITLE III, AND THEREBY ESTABLISHED A NATIVE HAWAIIANS STUDY COMMISSION TO ADVISE THE U.S. SENATE COMMITTEE ON ENERGY AND NATURAL RESOURCES AND THE U.S. HOUSE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS ON ISSUES OF CONCERN TO NATIVE HAWAIIANS; AND,

WHEREAS, THE LEGISLATURE OF THE STATE OF HAWAII ALSO HAS AN ABIDING AND DEEP COMMITMENT TO THE FULFILLMENT OF THE NATIONAL PURPOSES RELATING TO NATIVE HAWAIIANS AND TRULY AFFECTING ALL OF THE CITIZENS OF HAWAII; AND,

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Rincon Band of Luiseno

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WHEREAS, IT IS, THEREFORE, APPROPRIATE FOR THIS LEGISLATURE TO EXPRESS ITS FORMAL BELIEFS IN THE MATTER OF NATIVE HAWAIIAN CLAIMS AGAINST THE UNITED STATES FOR ACTIONS WHICH OCCURRED IN 1893, AND SUBSEQUENTLY WITH AMERICAN ANNEXATION OF THE ISLANDS OF HAWAII IN 1898; AND,

WHEREAS, BASED UPON A CAREFUL EXAMINATION OF HISTORICAL RECORDS AND ACCOUNTS THE LEGISLATURE OF THE STATE OF HAWAII HAS DETERMINED THERE IS SUFFICIENT REASON TO BELIEVE THAT:

1. THE UNITED STATES, THROUGH ITS REPRESENTATIVES IN THE STATE AND NAVY DEPARTMENTS, DID ENCOURAGE AND ACTIVELY SUPPORTED REBELLION AGAINST THE LEGITIMATE GOVERNMENT OF THE KING OF HAWAII;

2. THE INVOLVEMENT OF THE U.S. MINISTER JOHN L. STEVENS WAS CRUCIAL TO THE SUCCESS OF THE REBELLION, AND THAT HIS REFUSAL TO REMAIN NEUTRAL IN THE DOMESTIC AFFAIRS OF THE KINGDOM AND, INSTEAD, TO BECOME AN ACTIVE AGENT IN THE PLANNING AND MILITARY FORCE SUPPORTING THE INSURRECTION BY ORDERING THE LANDING AND PLACEMENT OF AMERICAN MARINES IN A MANNER AND POSITION UNMISTAKABLY INTENDED TO INTIMIDATE THE QUEEN OF HAWAII AND HER GOVERNMENT;

3. WITHOUT SUCH ARMED AMERICAN SUPPORT, THE INSURGENCE WOULD HAVE FAILED FOR A LACK OF POPULAR SUPPORT AND INSUFFICIENT ARMS; AND,

4. SUCH ACTIONS BY THE AMERICAN MINISTER AND FORCES WAS A BREACH OF INTERNATIONAL LAW, OF TREATIES WITH THE KINGDOM OF HAWAII, AND WAS CHARACTERIZED BY PRESIDENT GROVER CLEVELAND IN HIS "EXECUTIVE MESSAGE TO CONGRESS" (DECEMBER, 1893) AS AN ILLEGAL AND IMMORAL ACT OF WAR AGAINST A FEEBLE AND TRUSTING NATION; AND,

WHEREAS, BECAUSE OF THESE AMERICAN ACTIONS THE QUEEN YIELDED HER AUTHORITY AND THAT OF HER GOVERNMENT TO THE UNITED STATES THROUGH MINISTER STEVENS, WHO DID NOT FORWARD HER PLEA FOR REVIEW BY THE UNITED STATES BUT ACTED TO RECOGNIZE A PROVISIONAL GOVERNMENT COMPOSED OF LEADERS OF THE INSURRECTION AND TO DECLARE AN AMERICAN PROTECTORATE OVER THE ISLANDS; AND,

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WHEREAS, THESE ACTIONS WERE AUGMENTED TWO WEEKS LATER BY THE OCCUPATION OF AMERICAN TROOPS IN ALL GOVERNMENT BUILDINGS OF THE HAWAIIAN ISLANDS AT THE REQUEST OF THE PROVISIONAL GOVERNMENT FROM A FEAR OF BEING UNABLE TO MAINTAIN CONTROL; AND,

WHEREAS, THESE ACTIONS CULMINATED IN THE ASSERTION OF CONTROL BY THE SUBSEQUENT REPUBLIC OF HAWAII OVER THE CROWN, GOVERNMENT, AND PUBLIC LANDS OF THE KINGDOM OF HAWAII; AND,

WHEREAS, THESE STATE CONSTITUTIONAL PROVISIONS, AND THEIR CODIFICATION IN THE HAWAII REVISED STATUTES AS CHAPTER 10, DO INDEED ENDORSE AND ENCOURAGE NATIVE HAWAIIANS RIGHTS AND INTERESTS AS A SIGNIFICANT, PROPER, AND PUBLIC PURPOSE;

NOW, THEREFORE, BE IT RESOLVED THAT THE NATIONAL CONGRESS OF AMERICAN INDIANS RESPECTFULLY URGES THE CONGRESS OF THE UNITED STATES TO ACKNOWLEDGE THE ILLEGAL AND IMMORAL ACTIONS OF THE UNITED STATES IN THE OVERTHROW OF THE KINGDOM OF HAWAII IN 1893, AND TO INDICATE ITS COMMITMENT TO GRANT RESTITUTION FOR THE LOSSES AND DAMAGES SUFFERED BY NATIVE HAWAIIANS AS A RESULT OF THOSE WRONGFUL ACTIONS.

PROPOSED BY JOE DELACRUZ AND SUZAN SHOWN HARJO, MEMBERS IN GOOD STANDING.
ADOPTED UNANIMOUSLY BY THE 41ST ANNUAL NATIONAL CONGRESS OF AMERICAN INDIANS CONVENTION, SEPTEMBER 14, 1984, SPOKANE, WASHINGTON.

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MEMORANDUM

May 9, 1986

TO: THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

RE: THE NATURE OF THE FEDERAL-NATIVE HAWAIIAN RELATIONSHIP

FROM: PAUL ALEXANDER, FOR THE KAMEHAMEHA SCHOOLS / BERNICE PAUAHI BISHOP ESTATE

SUMMARY

The Federal Government has a trust relationship to Native Hawaiians. The relationship is premised on the course of dealings of the United States and its citizens with Native Hawaiians and their government, the explicit recognition of the relationship by the United States Congress in establishing the Native Hawaiian Home Lands Commission, and the recognition by the federal courts of the relationship. While most commentators agree that a trust relationship exists, there is little agreement as to the exact nature of any obligations that may be implicit in acknowledging such a relationship. It is probable that unless Hawaiian Native issues are addressed on a more comprehensive basis, such as they have been to some extent for many Indians and Alaskan Natives, the extent of the trust relationship for Native Hawaiians will remain unsettled. What is clear, however, is that Congress does possess the authority, pursuant to the Federal -Native Hawaiian relationship to enact legislation that is rationally related to the purposes of the trust relationship -- to legislate for the benefit of native Hawaiians.

THE HAWAIIAN QUESTION

The issue of the nature of the Federal-Hawaiian Native relationship usually arises in the context of whether the relationship is such that it justifies the provision of social services to Native Hawaiians. The question has sometimes been phrased as whether Native Hawaiians are "Indians" for the purposes of the Federal trust relationship, and whether therefore they can be included within any of the various programs that have been developed for Indians. While a number of legal arguments can be constructed to address the question of whether Native Hawaiians are legally the same as Indians[1]; these formulations do not clearly address the underlying issues. When Congress has determined that a trust relationship exists for an "indigenous group" within its political boundaries, Congress has the authority and the power to determine the perimeters of the social service aspect of that relationship. Whether services for Native Hawaiians should be identical to Indian services, provided through the same delivery systems, or different delivery systems, or a mix thereof, become policy issues. Issues that most likely will be influenced by the particular needs being addressed and the determination of the most effective delivery mechanisms that can be utilized to meet those needs. The key question is therefore - is there a identifiable Federal-Native Hawaiian relationship.

In addressing the above question it is helpful to review the Federal-Indian relationship and how it relates to the provision of social services. Much of the relevant law and underlying concepts concerning trust relations were formed to justify land transactions

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between Indian tribes first with the colonial European powers, then with the colonies, and finally with the United States. There are functional and legal analogies to be drawn between the Indian experience in North America, and the Native Hawaiian experience in dealings with the Western Colonial powers, the Republic of Hawaii, and the United States. The analogies are striking. What is also striking is the similarity of consequences. Both Indians and Hawaiians were left with a fraction of their original lands, and with severe social and economic consequences.

SERVICES AND THE FEDERAL-INDIAN RELATIONSHIP

A key concept of the Federal-Indian Relationship is the Federal trust responsibility. Chief Justice John Marshall in two related cases, Cherokee Nation v. Georgia, 30 U.S. (5 Pet.) 1 (1831), and Worcester v. Georgia, 31 U.S. (6 Pet.) 515 (1832), described Indian tribes as "domestic dependent nations" and characterized the relationship of the United States to the Indian tribes as one that "resembles that of a ward to his guardian." The responsibility to deal with Indians was constitutionally assigned to the Federal Government. This responsibility has become universally known as "the trust relationship." It is important to note that the responsibility has never been fully defined. Because a concrete definition of the trust responsibility might fail to take into account changing conditions and changing needs, the relationship can be described but not defined with any exactness. Indian people tend to define the trust as the responsibility that the Federal Government assumes from the operation of International law, the constitution, treaties and practice for the property and the well-being of Indian people.[2]

There are both mandatory and permissive aspects of the trust relationship. Because of the Federal-Indian relationship, the U.S. must exercise certain fiduciary standards with respect to Indian property. The existence of the relationship is also the basis for the provision of services that are not necessarily mandatory. The difference between what is a trust right and what is a trust-based service, often the subject of hard fought political and legal battles, is only occasionally a key issue in the actual delivery of services. [3] In what can be labeled the "trust mandated" or trust right situation, the beneficiaries can hold the trustee accountable, either in terms of monetary damages or equitable enforcement. In what can be termed the trust-based situation, Congress can provide distinct services to Indians; services that are insulated from challenge under the equal protection standards of the fourteenth amendment and similar standards incorporated in the fifth amendment to the Constitution. [4] Although Indians may not be able to require the United States to maintain a particular service or to provide damages for its withdrawal, in the trust-based situation, the existence of the trust does require that certain due process procedures be followed with respect to those services.[5]

Indian people tend to argue that many of the social services that are provided, such as health and education, are services mandated by the trust responsibility. The Executive Branch often argues that most Indian services are at best premised on the trust responsibility but are not required(trust-based). It argues that only services

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associated with trust property are the "true" trust services. Congress which constitutionally has the power to determine the extent of the trust, generally avoids the issue of determining whether any particular service is required by the trust relationship. [5] These issues are only infrequently addressed by the Courts, and when they are, they come up in unique factual situations, so that the issue of what services are trust rights or simply trust based is likely to remain unsettled. However, it is clear under Morton v. Mancari that in order for a program to exist it need only be rationally tied to United States' trust obligation.

There is a third class of services to which Indian tribes and people have access. These generally are services that are created by Congress to meet a defined social need and Indians are included as one of the many beneficiary groups. Although the trust relationship provides the basis for defining Indians as an eligible class in the general legislation, analytically such programs are neither trust mandated services, nor strictly speaking services based on the trust responsibility.

Unless Congress clearly established that a particular service is a right under the trust relationship, most federal services provided to Hawaiian Natives would seem to fall within the other permissible categories of services.

THE BASIS OF THE FEDERAL -HAWAIIAN NATIVE RELATIONSHIP

Most commentators and courts that have explored the question of the Federal-Hawaiian Native trust relationship have concluded that although the perimeters are not defined, as they are also not defined

for Indians, such a trust relationship exists.[7] It is based on the dependency of the indigenous Hawaiian Natives, and the recognition by the United States Congress of that status in the annexation of Hawaiian Islands, the establishment of the Hawaiian Homes Commission, and the Hawaiian Admissions (statehood) Act.

Felix Cohen's Handbook on Federal Indian Law [8] is the most prestigious and comprehensive treatment in the field. The 1982 edition says of Native Hawaiians:

> ...they are a people indigenous to the United States...however ...they have not been dealt with comprehensively by Congress.
> * * * *
> ...the full extent of the trust obligation owed by the United States to Native Hawaiians and the manner of its fulfillment has not been fully defined.[9]

The Congressional Research Service in response to a request from Senator Inouye reviewed the question and concluded:

> The courts have upheld the power of Congress to single Indians out for special treatment because of their unique status under the Constitution and treaties, and have inferred a trusteeship obligation on the part of the United States toward the aboriginal people that constitute the original inhabitants of lands now within the borders of the continental United States. ...The same reasoning that was used to infer a trust relationship between the United States government and the Indian tribes would seem to be capable of being applied to the relationship with Native Hawaiians.[10]

Several federal courts and the Supreme Court of Hawaii have had to address the issue of whether a trust relationship exists and all have concluded that it does. Perhaps the most misunderstood case in the area is Keaukaha-Pananewa Community Association v. Hawaiian Homes Commission,[11] known as Keaukaha I. This case considered whether a

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group of Native Hawaiians had standing as private parties to bring suit in federal court under the Hawaiian Homes Commission Act and/or the Hawaiian Admissions Act to prevent the Commission from transferring certain trust lands. Although the Court was clear that a trust for the benefit of Native Hawaiians had been established by these Acts, the administration of which was primarily with the state of Hawaii, the Court determined that a Federal question did not exist and that state court was the proper forum. In reaching that conclusion the 9th Circuit stated:

> It is clear, however that for all practical purposes these benefits have lost their federal nature.[12]

It has been suggested that this dicta of the 9th Circuit may be a barrier to asserting a Federal-Hawaiian Native Trust relationship. The statement should be understood in the context of Keaukaha I being a case pertaining to availability of remedies, not a definition of rights. Rights and remedies do not necessarily run together. It is quite clear in Indian law that many Indian "rights" have been what Justice Frankfurter once termed "hortatory" and required special acts of Congress to permit vindication of the those rights.[13] The fact that a number of Indian rights currently require remedies in State forums rather than Federal forums does not convert the Federal Indian right into a State right.[14] A more recent case covering the identical underlying factual issues and parties, known as Keaukaha II[15] determined that Native Hawaiians had a federal right enforceable under the 42 U.S. C. 1983, a reconstruction era civil rights statute. This decision should end any confusion over Hawaiian

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rights that remained under Kaaukaha I. Section 1983 actions are premised on the deprivation under the color of state law of a federal right. The Federal right required for the application section 1983 is the finding that the Hawaiian Admissions Act clearly "mandates the establishment of a trust for the betterment of native Hawaiians."

The Supreme Court of Hawaii in Ahuna v. Department of Hawaiian Home Lands, 64 Haw. 327, 640 P. 2d 1161 (1982) also has addressed the issue of Federal-Hawaiian Native Trust relationship in order to determine the obligations of the the Department of Hawaiian Home Lands. The Court determined that: 1) the legislative history of the Hawaiian Homes Commission Act indicates that the United States "stood in a trusteeship capacity to the aboriginal people" of Hawaii; and 2) the primary purpose of the Act " was the rehabilitation of native Hawaiians". The Hawaiian Supreme Court then utilized Federal-Indian law to determine the state agency's fiduciary obligation, as the instrumentality for effectuating the Federal purpose.

THE HISTORICAL RELATIONSHIP

A review of the history of relations between Hawaiian Natives and the United States demonstrates that there are significant parallels to aspects of U.S.-Indian history and gives credence to the observations of the commentators and the Courts.

It is been estimated that approximately 300,000 native people occupied the "Sandwich Islands", as Hawaii was then called when Western society discovered them in 1778. The indigenous Hawaiians had a complex political and economic but self-sufficient system in existence at time of contact. The system has been compared to the

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feudal system of medieval Europe. Private property --fee simple title--did not exist. Land occupancy rights ran from greater lords to lesser lords to commoners; obligations ran in reverse order.[16] Each island was autonomous until 1810 when Kamehameha I united the Islands by conquest and negotiation.

Certain similarities to the Indian situation at the time of discovery are pertinent. Both populations were politically autonomous, and both populations were self-sufficient in their traditional economies and life styles. Neither population had a private property system; but they did however control most, and in some cases all, of the lands within their political boundaries.

All of these situations would change. The various ways that Indians lands have been alienated from Indian ownership has been documented in proceedings of the Indian Claims Commission, and other sources. Interestingly, treaties which have become a major source of evidence in establishing a trust relationship, were often the instruments of land loss. The role of the United States in these transactions was fairly clear, it either directly obtained the Indian land or failed to protect the tribes in their land dealings.

The role of the United States in the Hawaiian loss of land was different in form than in the Indian situation but just as central. Treaties with the Native Hawaiian government were not land transactions but were means of assuring commercial access. The first treaty of peace and friendship proposed in 1826 was not ratified by the United States.[17] The first ratified treaty (1849)[18] dealt

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with friendship, commerce and navigation. A second treaty was entered into 1875; dealing with commercial reciprocity.[19] A final treaty, also concerning commercial reciprocity was entered into in 1884.[20] Throughout the 19th century, it would be the American merchants along with American missionaries who under the auspices of "civilizing" a system they felt was culturally inferior to their own would intervene with the military support of the United States government in internal Hawaiian affairs, beginning with the western style constitution of 1840 and ending in an insurrection against the Hawaiian monarchy.

During the first half of the 19th century, the merchants were supported by their respective Governments (French, British and American) by the use of naval war ships[21]. In effect the Westerners, and eventually the United States, using the threat of military force reduced the Kingdom of Hawaii to the functional equivalent of a dependent sovereign -- a suzerainty.

The influence of the western powers was greatly felt in the land system:

> By 1845, the land tenure system could neither maintain itself in the face of a hostile foreign world or accommodate itself to the wishes of that world.[22]

A land Commission dominated by Westerners was appointed. It would oversee the "Great Mahele" ; the end of the traditional Hawaiian land system and the substitution of a western style system of fee ownership. Cohen points out that:

> By destroying the interlocking communal nature of land tenure its [the Great Mahele] effect was similar to allotment and termination acts on the mainland.

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Land rights were concentrated in the hands of the very few. The King and the chiefs held title to 99 percent of all the lands. In a process not dissimilar to that which occurred with Indian lands after allotment, title to much of land was soon transferred to Non-Hawaiian ownership. Large plots of lands owned by royalty no longer had communal obligations attached and were therefore not productive without western capital or management systems. They were sold off at "distress prices" and fraud was not uncommon; ultimately a plantation economy with imported nonHawaiian labor was established. Small plots were also uneconomical and most were soon lost.

All commentaries seem to agree that in the second half of the 19th Century a small number of Westerners (2000) came to control most of the land in Hawaii:

> Native Hawaiians had been excluded from the mainstream of the economy; they had lost ownership of most privately held land and had been reduced to a minority of the inhabitants of the Kingdom.[23]

Control of land, however was not enough. The Westerners who by the latter part of the nineteenth century were primarily Americans, sought political control. As noted previously the first Hawaiian constitution of 1840 was procured by western influence. The constitution of 1887, known as the "Bayonet Constitution" was forced on the Monarchy by armed merchants -- American citizens. This constitution restricted the right to vote to those who paid taxes, including non-citizens. Native Hawaiians were disenfranchised and the American merchants obtained a virtual dictatorship. The last royal ruler of Hawaii, Queen Liliuokalani, came to the throne in 1892 and attempted to replace the "Bayonet constitution" with a new one

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that would have significantly eroded western power. Foreigners were to be precluded from obtaining citizenship or from voting. In January 1893, shortly before the new constitution was to go into effect, and while President Harrison, who favored annexation, was still in office, armed American merchants, aided by the U.S. minister in Hawaii, John L. Stevens, and marines from the U.S.S. Boston forced the Queen to relinquish her governmental authority. A provisional government dominated by american merchants was established. The government immediately sought annexation by the United States. The goal of annexation, however, would take a few years. Assuming office shortly after the overthrow of the Queen, President Cleveland, supported by the Blount report[24] refused to support annexation.[25] The Blount Report found that the overthrow of the Queen had been illegal; and recommended the she be restored to power. The Provisional government of Hawaii refused to follow Blount's recommendations and instead established the Republic of Hawaii. The Republic thereupon took over all crown or public lands without compensation .

Another report on annexation would be prepared by the Senate Foreign Relations Committee, known as the Morgan Report.[26] It approved the United States support of the merchants. It used a familiar theory...determining Hawaii to be a dependent sovereignty of the United States. An analogous theory to that used in the landmark decisions that gave judicial recognition to the Federal-Indian relationship, Worcester and Cherokee Nation. The report stated:

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> [It] is a recognized fact that Hawaii has been all the time under a virtual suzeraiaty of the United States...a de facto supremacy over the country.

A "suzerainty" was understood in International law to be the relationship that a more powerful sovereign has over a dependent one; the dependent sovereign was usually viewed as less "civilized " than the powerful sovereign.

After the Morgan Report, by a joint resolution of Congress the United States annexed Hawaii in 1898[27] Cohen states that with annexation "Native Hawaiians became a dependent indigenous people of the United States."[28]

Native Hawaiian conditions which were difficult at the time of annexation continued to deteriorate. Indian conditions were at same time also suffering from similar circumstances; loss of traditional life styles and food resources; loss of the native land base; and destruction of traditional modes of self-government. By the 1920's, reformers were concerned about the conditions of Native people. For Indians, the Red Cross survey of conditions, and the Meriam Commission report would result in a a partial reversal of many of the policies of the 19th century.

For Hawaiians Natives the concern would focus in the Hawaiian Homes Commission Act.[29]. The Act set aside 200,000 acres of land to be leased to Native Hawaiians for 99 years at nominal rates. Congress viewed the Hawaiian Homes Commission as a "plan for the rehabilitation of the Hawaiian Race." The bill was introduced by the nonvoting Delegate from Hawaii, J. K. Kalanianole, a member of the royal family of Hawaii based on a plan developed by Senator Wise.

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Hawaiians were thought to be a dying race, numbering a scant 22,500 in 1920. The House Committee Report[30] on the Homes Commission quotes from the hearing record to establish the cause of the problem it was attempting to remedy.

> Mr. Monahan. What caused this dying away of the race...
>
> Secretary [of the Interior] Lane. ...It is always incident to the comings of civilization and we always carry disease germs with us to which these people are not immune...

The Committee's response to any challenge to the bill's constitutionality as "unconstitutional class legislation" was to point out, among other arguments, that Congress had the authority to provide special benefits for unique groups such as "Indians, soldiers and sailors...". This is the same argument in embryonic form, that the Supreme Court would later use in Morton v. Mancari to sustain special programs for Indians. This statute is universally viewed as Congress' recognition of the special relationship the United States has to Native Hawaiians.

When Hawaii became a state in 1959, the dominant federal-Indian policy was then the terafination of Indian reservations and the transfer of much Federal administrative responsibility to States. It is therefore not surprising that the Hawaiian Homes Commission was made part of the responsibilities of the state of Hawaii upon Hawaii's admission to the union. Since the rights involved were Federal, Federal responsibility was retained. Any changes proposed by the State that could impair Hawaiian Native rights require Congressional consent, and the United States is the only party with

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specific standing to sue in federal courts to enforce the provisions of the trust.[31]

Since statehood Congress has periodically legislated for the benefit of Native Hawaiians.[32] It has not, however, comprehensively addressed Hawaiian Native issues. This situation is not entirely different from the Federal-Indian relationship, which also has not been comprehensively spelled out. Many of the Indian programs are premised on general statutory authority. The Executive branch has been allowed great latitude in defining the nature and scope of programs.[33] Absent an express direction from Congress, the agencies operating federal programs have not included Hawaiian Natives. Although it is possibly administratively feasible to include Hawaiian Natives, given the broad discretion asserted by federal agencies, inclusion of of the Hawaiian Native population in federal program by agency action is not very likely. Department of Interior regulations on tribal recognition apply only in the continental United States and therefore exclude Hawaiians.[34] Furthermore most agency activity in the last decade has focused on reducing beneficiaries by narrowing eligibility criteria.

In many ways, native Hawaiian issues resemble those of Native Alaskans prior to the Alaskan Native Claims Settlement Act. In addressing the issue of whether "Eskimos" were "Indians" even though not of the same racial origin, courts have determined that the term "Indians" is not a racial classification but a term of art for the aboriginal peoples of America.[35] "Alaskan natives were sometimes included in Indian programs, although not always. Periodically

programs were passed for Alaskan Natives that did not have Indian counterparts.[36] Alaskan Natives with several exceptions did not have reservations or trustlands. In addition to resolving Alaskan land claims, the Settlement Act provided for a comprehensive definition of Alaskan natives, and the creation of a series of entities, including existing traditional Native villages, as the mechanisms for land holding as well as service delivery. These mechanisms which have no counterpart in Indian affairs in the lower-forty eight states, but have become routine parts of of the Federal-Alaskan Native relationship.

Many distinct issues, and many divergent views exist on the subject of Hawaiian Lands Claims. Absent such a comprehensive approach to Hawaiian issues, as was provided for Alaskan Natives by the Alaskan Claims Settlement Act, or some other comprehensive mechanism, Congress will on a by-case basis whether any particular program should be part of the the Federal-Hawaiian relationship. As Cohen has stated"..there is no reason to doubt that Congress has power to legislate specifically for the benefit of Native Hawaiians".[37]

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FOOTNOTES:

1 The argument is based on applying considerations set out in Cohen's Handbbok of Federal Indian Law, infra, n. 8, that "singly or jointly, have been relied upon in reaching the conclusion that a group consitutes a tribe" of Indians. These include the treaties bewtween the U.S. and Hawaii; recognition of Hawaiians as an aboriginal group in various Congressional Acts; collective rights in rights in land under the Hawaiian Homes Commission Act; and recognition of Hawaiian Natives as an aboriginal group by other Native groups. Contra, Price v. State of Hawaii, 764 F.2d 623 (9th Cir. 1985) applying recognition criteria to a specific Hawaiian entity.

2 See, e.g. U.S. Congress, American Indian Policy Review Commission, Final report of the American Indian Policy Review Commission (Washington, D.C.:U.S. Government Printing Office, 1977)

3 See White v. Califano, 437 F. Supp. 543 (D.S.D. 1977), aff'd 581 F.2d 697 (8th Cir. 1978) and McNabb v. Heckler, N. CU-83-051-GF (D. Mont. 1986).

4 Morton v. Mancari,417 U.S. 535 (1974).

5 See e.g., Fox v. Morton, 505 F.2d 254 (9th Cir. 1974); Vigil v. Andrus 667 F. 2d 931 (10th Cir.. 1982); and Wison v. Watt 703 F.2d 395 (10th Cir. 1983).

6 But see, The Indian Health Care Improvement Act findings which state: "...health services to maintain and improve health of Indians are consonant with and required by the Fedneral government's historical and unique relationship with, and result in responsibility to, the American Indian people." 25 U.S.C. sec 1601.

7 The Hawaiian Study Commission majority report acknowledges a "very limited special trust" and the minority report argues for a broader trust. Either view would support rationally related services.

8 1982 Edition.

9 Ibid, at 797-798.

10 November 2, 1983 memorandum from the Congressional Research Service, Library of Congress, to Senator Daniel K. Inouye, Definition of Native Hawaiians, at 1-2.

11 588 F.2d 1216 (9th Cir. 1978).

12 Ibid, at 1226.

13 The establishment of the Indian Claims Commission was in direct response to the inability to otherwise pursue claims.

FOOTNOTES:

[14] See e.g., P.L. 83-280 which permitted states to assume specified jurisdiction over Indians.

[15] Keaukaha-Panaewa Community Association v. Hawaiian Homes Commission, 739 F.2d 1467 (9th Cir. 1984).

[16] N. Levy, Native Hawaiian Land Rights, 63 Cal L Rev 848 (1975) provides an extensive discussion of these matters and is relied upon throughout this paper.

[17] Treaty with Hawaii on Commerce, Dec. 23, 1826, United States-Hawaii, 3 C. Bevans, Treaties and Other Internal Agreements of the United States, 1776-1949, at 861 (1971).

[18] Treaty with Hawaii on Friendship, Commerce and Navigation, Dec. 20, 1849, U.S.-Hawaii, 9 Stat. 977.

[19] Treaty with Hawaii on Commercial Reciprocity, Jan. 30, 1875, U.S.-Hawaii, 19 Stat. 625.

[20] Treaty with Hawaii on Commercial Reciprocity, Dec. 6, 1884, U.S. -Hawaii, 25 Stat. 1399.

[21] Levy, supra, n.16 at 852.

[22] Ibid, at 853.

[23] Cohen, supra, n.8, at 800.

[24] James Blount was the former Chairman of the House of Representatives Committee on Foreign Affairs, appointed as Special Commissioner to Hawaii. See, Kuykendall, The Hawaiian Kingdom, The Kalakaua Dynasty (1967)for an in depth treatment of this era in Hawaiian affairs.

[25] President's Message Relating to the Hawaiian Islands, H.R. Exec. Doc. No. 47, 53d Cong., 2d Sess., XIV-XV (1393).

[26] S. Rep. No. 227, 53rd Cong., 2d Sess. (1893).

[27] 30 Stat. 750 (1898).

[28] Supra,n. 8, at 802.

[29] 42 Stat. 108 (1921).

[30] H.R. Rep. No. 839, 66th Cong., 2d Sess. 4 (1920).

[31] P.L. 86-3, set out in full in 48 U.S.C. prec. sec. 491.

[32] See e.g., 16 U.S.C. sec. 396a (leases in Hawaii National Park); 21 U.S.C. sec. 1177(d)(National Institute on Drug Abuse); 42 U.S.C. sec.1996 (Indian Religious Freedom Act); 42 U.S.C. sec 2991(a) (Administration for Native Americans); and similar legislation.

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FOOTNOTES:

[33] Morton v. Ruiz, 415 U.S. 199, 231 (1974) " the power of an administrative agency to administer a congressionally created and funded program necessarily requires the formulation of policy and the making of rules to fill any gap left implicitly or explicitly by Congress."

[34] 25 C.F.R. 54.2.

[35] Pence v. Kleppe, 529 F.2d 135 (9th Cir. 1976)

[36] For example the importation of Reindeer for benefit of Alaskan Natives, 25 U.S.C. sec 500.

[37] Supra, n. 8, at 803.

FEDERAL-STATE TASK FORCE ON THE HAWAIIAN HOMES COMMISSION ACT

REPORT TO

UNITED STATES SECRETARY OF THE INTERIOR AND THE GOVERNOR OF THE STATE OF HAWAII

HONOLULU, HAWAII
AUGUST, 1983

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APPENDIX 6

BACKGROUND PAPER
FEDERAL RESPONSIBILITIES

What are the responsibilities of the United States with respect to the program of the Hawaiian Homes Commission?

Short answer:

The responsibilities of the United States concerning the Hawaiian Homes Commission program derive from three statutory sources: Section 4 of the Hawaii Statehood Act, section 5(f) of that Act, and section 204(3) of the Hawaiian Homes Commission Act, as amended.

Section 4 of the Statehood Act permits the State of Hawaii to amend the Homes Commission Act, but certain amendments require "the consent of the United States." When such consent is required, it is the responsibility of the United States to give conscientious and expeditious consideration to granting it.

Section 5(f) of the Statehood Act provides that the lands granted to the State by the Act, which include all "available lands" under the Hawaiian Homes Commission Act, are "to be held by the State as a public trust." All such lands, together with proceeds from their disposition and income derived from them, may be used only for five purposes expressly stated, one of which is "the betterment of the conditions of native Hawaiians, as defined in the Hawaiian Homes Commission Act, 1920, as amended." If the lands granted to the State are used for any purpose other than the five purposes stated, then that use "shall constitute a breach of trust for which suit may be brought by the United States." It seems proper to conclude that the United States has under section 5(f) a responsibility

-- to be aware of the manner in which the State manages or disposes of the lands and revenue derived from them that constitute the section 5(f) trust;

-- to satisfy itself from time to time that the State is not abusing its responsibility as trustee; and

-- should it conclude that the State is failing properly to discharge its responsibility under section 5(f), then to institute proceedings against it for breach of trust.

Section 204(3) of the Hawaiian Homes Commission Act, 1920, as amended, provides that the Department of Hawaiian Homes Lands may exchange "available lands" for public or private land of an equal value, if the exchange will "consolidate its holdings . . . or better effectuate the purpose" of the Act, and if "the approval of the Secretary of the Interior" is obtained.* All exchanges consummated since Statehood have had that approval. When the State of Hawaii seeks the approval of the Secretary of the Interior under section 204(3) of the Homes Commission Act, it is the Secretary's responsibility to give conscientious and expeditious consideration to granting it.

It has been argued additionally that the United States serves as a trustee with respect to Hawaiian home lands, and that it owes a fiduciary duty toward native Hawaiians. The only Federal court that has addressed the question has stated that that is not so, and that the United States instead has only a "somewhat tangential, supervisory role" with respect to the Homes Commission program. But support may be derived from other sources for the contrary view.

In any event, the United States should bear responsibility for past and/or present misuses of Hawaiian home lands, as discussed elsewhere in the work of the Task Force, particularly in the Background Paper on Remedies for Improper Land Use by NonBeneficiaries.

Elaboration:
Section 4 of the Statehood Act:

The consent requirement imposed by section 4 of the Statehood Act is the subject of a separate Background Paper for use of the Task Force detailing which amendments to the Homes Commission Act since 1959 are subject to "the consent of the United States," and recommending that such consent be sought forthwith. These matters require no further discussion here.

Two other aspects of the consent requirement, however, warrant

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*As orginally enacted, the Hawaiian Homes Commission Act imposed several other responsibilities on the Secretary of the Interior, but except for the reference in section 204(3), he was relieved of those responsibilities and all references to him were removed by action of the 1978 State Constitutional Convention. In addition, the Secretary of the Interior appears in one other later-enacted section, section 224 enacted in 1935. So far as can be established, section 224 has never been implemented. Section 224 provides that the Secretary "shall designate from his Department someone experienced in sanitation, rehabilitation, and reclamation work" to live in Hawaii and work with the Hawaiian Homes program. A $6,000 ceiling on his annual salary, which must be paid by the Department of Hawaiian Home Lands, was eliminated in 1976, something that could be achieved without the consent of the United States because its subject matter is "administration".

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brief consideration. First, how should U.S. consent be evidenced? The literature associated with section 4--both its legislative history and learned commentary since--indicates no dissent from the proposition that the consent must be evidenced by act of Congress.* While Federal consent is sometimes evidenced by approval of the President or of some lesser officer, that is invariably stipulated in the governing statute, and there is no such stipulation here. It appears that the State of Hawaii agrees that Federal legislation is necessary to evidence consent, for the effectiveness of some recent amendments to the Hawaiian Homes Commission Act has been made contingent upon obtaining "the consent of the United States Congress". (See, for example, Session Laws of Hawaii, 1981, Act 112, Section 5).

Then, secondly, how can legislation to evidence that consent be initiated? As the related Background Paper on this issue states, either a Member of Congress could sponsor the necessary bill, or an appropriate officer of the Executive Branch could submit it to the Congress as proposed legislation. The State of Hawaii could choose either route, as it prefers. If the Secretary of the Interior were to agree with the recommendation that follows below, i.e., that he appoint an officer in his Department as the contact point within the Executive Branch on matters concerning the Hawaiian Homes Commission Act, then if the State chose the Executive Branch alternative, there would be particular logic in its asking the the Interior Department to initiate appropriate legislation.

Section 5(f) of the Statehood Act:

Section 5(f) provides that the lands granted to the new State of Hawaii by the United States in that Act are "to be held by said State as a public trust." The lands so granted are the "public lands" in Hawaii to which the United States held title immediately preceding admission (with exceptions not now relevant), and the "available lands" that are defined as such in the dawaiian Homes Commission Act. These lands and the revenues arising from them are to be used for five purposes only: to support public education, to develop farm and home ownership, for public improvements, for public use, and "for the betterment of the conditions of native Hawaiians, as defined in the Hawaiian Homes Commission Act, 1920, as amended." Use for any other purpose constitutes "a breach of trust for which suit may be brought by the United States."

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* There is attached hereto a document prepared for the use of the Task Force and entitled "Citations to and Extracts from the Legislative History of the Hawaii Statehood Act as it pertains to the Hawaiian Homes Commission Act, 1920". Comments concerning the legislative history of the statutory provisions discussed herein are based on the information contained in that document.

By its terms, the trust imposed by section 5(f) pertains to all public lands conveyed to the new State by the Statehood Act, and not just to Hawaiian home lands. The beneficiaries of the trust are, under section 5(f), not just native Hawaiians, but all citizens of Hawaii. (Keaukaha-Panaewa Com. v. Hawaiian Homes Com'n, 588 F.2d 1216, 1223 (1978)). However, Hawaiian home lands, i.e., "available lands," cannot be used for any purpose other than "the betterment of the conditions of native Hawaiians" because

-- Section 4 of the Statehood Act, which requires the Federal-State "compact," states that "all proceeds and income from the 'available lands,' as defined by [the Hawaiian Homes Commission] . . . Act shall be used only in carrying out the provisions of said Act";

-- Section 3 of Article XII of the Hawaii State Constitution contains virtually the same language as that just quoted;* and

-- Section 4 of Article XII of the State Constitution excludes "available lands" from others upon which the trust is imposed by the Statehood Act, so that "available lands" could not be used to benefit the remainder of the Hawaii public.

For assistance in understanding what section 5(f) means, some guidance may be found in the decision of the Court of Appeals for the Ninth Circuit, cited above, and the legislative history of the section. So far as it is currently pertinent, Keaukaha-Panaewa Com. v. Hawaiian Homes Com'n, supra, states (at 588 F.2d 1224):

-- "With Hawaii's admission into the Union, the National Government virtually relinquished its control over and interest in the Hawaiian home lands. The problem described in plaintiffs' complaint [concerning alleged misdeeds of the Hawaiian Homes Commission] is essentially a matter of State concern. We deem it most appropriate for Hawaii's laws and judicial system to deal with it."

-- With respect to section 5(f) lands, "the State is the trustee . . . and the United States has the opportunity to sue the State only on the basis of a right reserved by Congress in the State's Admission Act. The United States has only a somewhat tangential supervisory role under the Admission Act, rather than the role of trustee."**

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* The qualifier ("virtually") is required in the interest of full scrupulosity: "said Act" in section 4 is "such Act" in the State Constitution.

** The first of these two quotations from Keaukaha-Panaewa is contained in the body of the opinion, while the second appears in a footnote. Some may contend that both constitute dicta only, but that contention is at least arguable. More importantly, however, after the Keaukaha-Panaewa decision was announced, the Deputy Solicitor of the Interior Department stated in 1979 that notwithstanding it, the United States is a trustee for the Hawaiian Homes program. His position is set forth more fully below under the heading "The trust question".

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The legislative history of section 5(f) provides no illumination concerning its meaning, apart from leading the researcher to earlier Statehood acts that contain somewhat similar provisions. The statutes for New Mexico and Arizona contain provisions requiring the new State to hold "in trust" Federal public lands granted upon admission, and providing that the disposition of lands contrary to the statute "shall be deemed a breach of trust." And they provide further:

> It shall be the duty of the Attorney-General of the United States to prosecute in the name of the United States and in its courts such proceedings at law or in equity as may from time to time be necessary and appropriate to enforce the provisions hereof. (36 Stat. 564-5, 575.)

In connection with each of these States, the trust provision has been before the Supreme Court, but the two decisions-while making clear the authority of the United States to impose trust conditions in enabling acts, and while asserting the continued effectiveness of those conditions--are not of great value in defining the Federal role. (Ervien v. U.S., 251 U.S. 41 (1919), concerning New Mexico; Lassen v. Arizona Highway Dept., 385 U.S. 458 (1967), concerning Arizona.) The United States Attorney General did not institute the Arizona action (although it will be noted that doing so was described in the admission act as his "duty"), but the Court did observe in Lassen that

> . . . the most recent [land grants to new States] commonly make clear that the United States has a continuing interest in the administration of both the lands and the funds which derive from them. (p. 460)

And this interest is manifested by the authority vested in the U.S. Attorney General to maintain enforcement proceedings. But in each case, the State of New Mexico or the State of Arizona or "any citizen thereof" may also bring an action to enforce the trust (36 Stat. 565, 575).

Setting aside temporarily the question whether there is a Federal trust responsibility, in light of the language of the Hawaii Statehood Act, and of the foregoing discussion of such aids as exist to its construction, it seems proper to conclude, that the United States has under section 5(f) a responsibility:

-- to be aware of the manner in which the State manages or disposes of the lands, including but not limited to Hawaiian home lands, and revenues derived from them, that constitute the section 5(f) trust;

-- to satisfy itself from time to time that the State is not abusing its responsibility as trustee; and

-- should it conclude that the State is failing properly to discharge its responsibility under section 5(f), then to institute proceedings against it for breach of trust.

Given the current organization of the Executive Branch of the Federal Government and the current responsibilities of particular departments, it is probable that the Department of Justice and the Department of the Interior would cooperate on all three subjects, but that the former would alone actually institute litigation, should that ever become appropriate. In discharging the other obligations referred to above, a number of techniques would be available to either or both of those Departments: (a) Each has personnel already assigned to Hawaii, and such personnel might be diverted from their regular duties for a time and asked to review portions of the Homes Commission program, for the benefit of their superiors in Washington. (b) The Interior Department has already caused its Inspector General to conduct an audit of the program, and a further audit or an audit followup, as appropriate, by such Federal personnel might reasonably follow. (c) Federal personnel, particularly experts on matters relevant to the Homes Commission program, might be made available to the State, to provide technical assistance. (d) Or such personnel might be made available to work with State appointees in the manner of the current Task Force, in an effort mutually to develop recommendations for improved Homes Commission programs.

In any event, the United States, acting through the Department of the Interior, should undertake within two years of the date of the Task Force report, to assess formally the progress made in correcting problems identified by the Task Force, using one or more of the methods described above.

Section 204(3) of the Hawaiian Homes Commission Act:

Section 204(3) provides in pertinent part that

> The Department [of Hawaiian Home Lands] may, with the approval of the Secretary of the Interior, in order to consolidate its holdings or to better effectuate the purposes of this Act, exchange the title to available lands for land, privately or publicly owned, of an equal value.

There have been five exchanges since August 1959, and the Secretary of the Interior has approved each. In connection with one such exchange, an Assistant Secretary of the Interior observed in 1972, in a memorandumn to the Director of the Department of Hawaiian Home Lands, as quoted in the recent audit of Homes Commission programs by Interior's Inspector General.

> Such approval by the Secretary is considered by the Department to be a ministerial, nondiscretionary act which he cannot perform until after the Governor has acted. The lack of suitable personnel representing the Department of the Interior in Hawaii to investigate the proposed land exchanges reflects the ministerial nature of the Secretary's function. Thus, Section 204(4) [amended in 1978 to become Section 204(3)] insofar as it requires the Secretary's approval in cases involving land exchanges, represents something of an anachronism which has carried over from the days of territorial status when Hawaii was under the jurisdiction of the Department of the Interior.

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An "anachronism" it may be, but the section was amended as recently as 1978 by the Hawaii Constitutional Convention to eliminate the need for the Governor's approval of exchanges, but to leave undisturbed the requirement for approval by the Secretary of the Interior.*

Another Secretary of the Interior (or Assistant Secretary of the Interior vested with pertinent Secretarial authority) might or might not agree with the policy position stated above. The extent to which a Secretary is prepared to secondguess the Governor of Hawaii and his subordinates by probing into the details of a particular land exchange may well differ among Secretaries. It is clear that the Interior Department has, for example, for several decades articulated a policy of full deference to local governments on local questions as they arise in the territories of the United States. The Secretary of the Interior has been disinclined to question the wisdom of territorial decision-makers on local issues.

But on the other hand, a Secretary of the Interior who serves solely as a rubber stamp on section 204 exchanges risks violating the statute. In his "Review of Hawaiian Homes Commission Programs", the Interior Department's Inspector General points to three exchanges approved by the Secretary that probably did not meet the requirements of section 204. Two involved exchanges of tracts of

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*It may be wondered whether the U.S. Congress, if it chose, could remove the Secretary from this section, or indeed whether the U.S. Congress might in any way modify the requirements it imposed in section 4 concerning the amendment to the Homes Commission Act. The answer appears to be no to both questions, but for different reasons. The Congress has in effect transferred to the State of Hawaii the power to amend the Homes Commission Act, and the State of Hawaii may do so without the consent of the U.S. if the amendment pertains to "administration" or to the powers of officers other than those charged with the administration of the Act. The elimination of the Secretary from section 204(3) seems to be both. Thus, the State of Hawaii could eliminate the Secretary from section 204(3), but there is doubt as to whether the Congress on its own initiative could do so. As to the amendment by the Congress of section 4 of the Statehood Act, that section is by its terms "a compact," and a compact is by definition bilateral. Both the United States and Hawaii would need to agree to the amendment, and given the requirement of the Statehood Act that the voters of Hawaii were to agree to its terms (and particularly the terms of section 4) as a condition precedent to its effectiveness--and indeed to Hawaii's admission--it seems clear that a popular referendum would be necessary in Hawaii to ratify any change. Action by the State Legislature would not alone be sufficient. In any event, the two governments would probably have to act in concert. The State cannot change the compact unilaterally, given the constitutional prohibition in Article I, section 10, against the impairment of contracts. And while the law on the subject is slight (see Grad, Frank P., Federal-State Compact: A New Experiment in Co-operative Federalism, 63 Columbia L.R. 825, 848 (1963)), the United States would probably violate the due process clause if it undertook to act alone. (Lynch v. U.S., 292 U.S. 571, 579 (1934)).

precisely equal size. They were almost certainly, then, not of equal value, which is what the statute requires. A third involved an exchange of public land as it had been valued for tax purposes in 1966, for Hawaiian home lands as they had been valued for tax purposes over the period 1962-1966, indicating that the home lands were in all likelihood relatively under-valued. Hence, the Secretary of the Interior can probably meet his section 204(3) responsibilities by paying considerable deference to State officials, but he ought not to abdicate wholly to them lest statutory standards not be met. The Secretary should review exchanges sufficiently to be certain that at least there has been full compliance with the law. In addition, the Secretary should establish procedures to assure that land exchanges receive prompt and careful consideration, and the office with responsibility for their initial consideration should be identified and made known.

The trust question

The question arises as to whether the responsibilities above described are the only ones the Federal Government now has for the Hawaiian Homes Commission program. Does a recital of these three sections from the Statehood Act and the Homes Commission begin and end the description of the responsibility of the United States?

Responsible observers are not now of one mind as to the answer. Some contend that the United States had before Statehood, and has retained since Statehood, the role of a trustee with respect to Hawaiian home lands. They consider that the United States thus owes a fiduciary duty in its treatment of the beneficiaries of the Homes Commission program. In support, those who hold this view point to a recent decision of the Hawaii Supreme Court (Ahuna v. Department of Hawaiian Home Lands, ____ Haw. ____ (1982)), in which Chief Justice Richardson stated that

-- the legislative history of the Homes Commission Act "strongly suggests that the federal government stood in a trusteeship capacity to the aboriginal people", and

-- the "tenor" of Congressional committee language "implies an intent to establish a trust relationship between the government and Hawaiian persons".

A position to the same effect was expressed in 1979 by the Deputy Solicitor of the Department of the Interior, in a letter to the Western Regional Office of the U.S. Commission on Civil Rights. He wrote that

-- "Prior to statehood, the United States itself held title to the home lands in trust for native Hawaiians"; and

-- since statehood, "it is the Department's position that the role of the United States under section 5(f) is essentially that of a trustee".*

If a trusteeship relationship were to be established, then the enormous body of law pertaining to the relationship between the Federal Government and American Indians might become relevant -- although the Deputy Solicitor in 1979 stated in the above letter that that relationship "may or may not be analogous" to the position of native Hawaiians.

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*As earlier stated, the Deputy Solicitor's letter of August 27, 1979, was written after the Keaukaha-Panaewa decision. The Deputy Solicitor's full comment on this point, from which the above excerpts are derived, is as follows:

> The Ninth Circuit in construing section 5(f) recently stated: ". . . the state is the trustee . . .*** The United States has only a somewhat tangential supervisory role under the Admission Act, rather than the role of trustee." Keaukaha-Panaewa Community Assoc. v. Hawaiian Homes Commission, supra, 588 F. 2d at 1224, n. 7. It is true that the state, rather than the United States, holds title to the Hawaiian Home Lands for the use and benefit of native Hawaiians, while the United States' trust responsibility with respect to Indian Lands is due in large part to the fact that the United States holds legal title to the land in trust for Indian tribes and individual Indians. Nonetheless, it is the Department's position that the role of the United States under section 5(f) is essentially that of a trustee. Prior to statehood, the United States itself held title to the home lands in trust for native Hawaiians. The terms of that trust were defined by the provisions of the Hawaiian Home Commission Act, 1920. Although the United States transferred the lands and the responsibility for administering the act to the state under the Admission Act, the Secretary of the Interior retained certain responsibilities, discussed below, which should be considered to be more than merely ministerial or nondiscretionary. The United States further provided that no substantive changes in the act, and thus in the terms of the trust itself, may be made without the consent of Congress and also retained authority to prosecute breaches of the trust. Taken together, the responsibilities of the federal government are more than merely supervisory and the United States can be said to have retained its role as trustee under the act while making the state its instrument for carrying out the trust. Cf. Act of August 4, 1947, c. 458, § 1, 61 Stat. 731, 25 U.S.C. 355 note (1976 ed.); Springer v. Townsend, 336 F. 2d 397 (10th Cir. 1964)(state court, in approving, pursuant to federal statute, conveyance of restricted Indian land, acted as federal instrumentality).

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Those who doubt that the United States has a trust responsibility toward native Hawaiians under the Homes Commission Act or the Statehood Act or both are likely to argue from the absence of any trust language applicable to the United States in any pertinent and from the absence of any words in the pertinent statute, legislative histories suggesting that a trust was in the legislators' minds. The trust language in section 5(f) of the Statehood Act unarguably relates by its terms to the State alone. No other terms that are commonly associated with trusts appear anywhere. In Keaukaha-Panaewa Com. v. Hawaiian Homes Com'n, discussed above in relation to section 5(f), the United States Court of Appeals for the Ninth Circuit seems to have found the statutory language dispositive. On the basis of it, the court held that the United States is not a trustee; the "state is the trustee"; and Indian cases are therefore not helpful in terms of who may sue for breach of trust. In sum, those who believe the United States is not a trustee for the Homes Commission program may assert that there is no persuasive evidence that a trust relationship with the Federal Government now exists, or was ever intended to be created.

The question whether the United States was or was not, or is or is not, a trustee in relation to the Hawaiian Homes Commission program is likely to be argued indefinitely. The Task Force needs to be aware of the issue and of the essence of the argument of either side, but a Task Force position on the legal issue is unlikely to have value to anyone, either now or in the future. A task force position surely will not dispose of the question, nor will it be otherwise productive so there seems no merit in attempting to adopt one.

Regardless, however, of the trust issue, the United States should bear responsibility for past and present misuses of Hawaiian home lands, as discussed in the Background Paper on Remedies for Improper Land Use by Non-Beneficiaries.

Interior Department Machinery:

To assist the Secretary of the Interior in knowing whether a particular land exchange should be approved, to assist the Government of the United States more generally in discharging the responsibilities it has under section 5(f), as outlined earlier in this paper, and to assist beneficiaries of the Act who may want to bring to the attention of the United States matters having to do with the administration of the Act, the Secretary should be asked to name an officer or employee of the Department of the Interior as a point of contact on matters touching the Hawaiian Homes Commission Act. At all times there should be such an officer or employee so designated. That would afford concerned citizens of Hawaii, as well as officers and agencies in Hawaii and in Washington, with an available and knowledgeable source to which questions can be put and to which information on the Homes Commission program may be supplied. It would assist not only the Secretary in the discharge of his approval authority, but also the Government of the United States generally in the discharge of its responsibilities under sections 4 and 5(f) of the Statehood Act.

In addition, the Interior Department should join the State of Hawaii in assisting the Department of Hawaiian Homes Lands in resolving questionable withdrawals and uses of home lands, and in channeling and monitoring claims against Federal agencies for improper uses of home lands.

APPENDIX 7

BACKGROUND PAPER

STATE TRUST RESPONSIBILITIES

I. INTRODUCTION

When Hawaii attained statehood in 1959, the new state entered into a compact with the United States whereby the Hawaiian Homes Commission Act (HHCA) was adopted as a provision of the State Constitution.1/ The compact also required that all proceeds and income from Hawaiian Home lands designated as "available lands" could only be used in carrying out the provisions of the HHCA.

Section 5(f) of the Admission Act provided that federal lands granted to the state upon admission were to be held by the state as a public trust for several purposes including the betterment of the conditions of native Hawaiians as defined in the HHCA.

The state and its people reaffirmed this compact by adding another provision to the Constitution whereby they accepted specific trust obligations relating to the management of the Hawaiian Home lands imposed by the federal government. This provision specifies that:

> Section 2. The State and its people do hereby accept, as a compact with the United States, or as conditions or trust provisions imposed by the United States, relating to the management and disposition of the Hawaiian home lands, the requirement that section 1 hereof be included in this constitution, in whole or in part, it being intended that the Act or acts of Congress pertaining thereto shall be definitive of the extent and nature of such compact, conditions or trust provisions, as the case may be. The State and its people do further agree and declare that the spirit of the Hawaiian Homes Commission Act

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1/ Admission Act of March 18, 1959, Pub. L. No. 86-3, §4, 73 Stat. 4, reprinted in 1 Haw. Rev. Stat. 78 (1976).

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> looking to the continuance of the Hawaiian homes projects for the further rehabilitation of the Hawaiian race shall be faithfully carried out. [Ren and am Const Con 1978 and election Nov 7, 1978]

Despite these provisions of the State Constitution, the precise nature of the trust obligations assumed by the State and its people towards native Hawaiians has not been fully determined.

II. THE NATURE OF THE STATE TRUST OBLIGATIONS OWED TO THE BENEFICIARIES

Recent court decisions have clarified the scope of the trust responsibilities owed by the Hawaiian Homes Commission.

The Hawaii Supreme Court recognized that the purpose of the HHCA was to rehabilitate the native Hawaiians on lands given the status of Hawaiian Home lands. In Re Ainoa, 60 Haw. 487 (1979).

In Ahuna v. Department of Hawaiian Home Lands, 64 Haw. 327 (1982), the Hawaii Supreme Court reviewed the history of the Hawaiian Homes program in detail. The court determined that in dealing with eligible native Hawaiians collectively or individually, the Hawaiian Homes Commission must adhere to the most exacting fiduciary standards and indicated that it would strictly scrutinize the actions of the government in administering this trust on behalf of the beneficiaries.

In Ahuna, the Court determined the extent and nature of the trust obligations owed by the Hawaiian Homes Commission by examining principles established by federal courts in interpreting trusts which benefit other native Americans such as American Indians. Noting that federal courts have determined that the conduct of the government as a trustee is measured by the same strict standards applicable to private trustees, the Ahuna court adopted a similar standard for the trust created for native Hawaiians under the HHCA. The specific trust obligations of a private trustee are well established.

A. THE OBLIGATION TO ADMINISTER THE TRUST SOLELY IN THE INTEREST OF THE BENEFICIARY

One specific duty of a trustee is the obligation to administer the trust exclusively in the interest of the beneficiary. In Ahuna, the Hawaii Supreme Court ruled that the Department of Hawaiian Home Lands breached this trust duty by impermissibly weighing the interests of the State of Hawaii and its taxpayers and withholding an award of a portion of a farm lot to a beneficiary because the homestead award might later interfere with a county roadway extension projected to extend through the area. Similarly, in Keaukaha-Panaewa Community Association v. Hawaiian Homes Commission, Civ. No. 75-0260, a U.S. District Court Judge ruled that the Hawaiian Homes Commission breached its trust duties by allowing the needs of the general public, as opposed to the needs of native Hawaiians, to control decisions made to allow a county flood control project to be constructed across Hawaiian Home lands.2/

It now seems well established that the Department of Hawaiian Home Lands, unlike other state agencies, may not allow public needs to influence its decisions in administering Hawaiian Home lands. Other Task Force findings demonstrate that the Hawaiian Homes Commission has breached this trust obligation many times in the past by allowing Hawaiian Home lands to be taken by other government entities because of public needs for airports, military reservations, parks, forest reserves, schools and other facilities.3/ Such projects may provide benefits for the general public, but have not provided compensation or direct benefits to the trust or its beneficiaries. State and county departments must recognize that the primary responsibility of the Hawaiian Homes Commission is to use Hawaiian Home lands to produce benefits and revenues for the beneficiaries of the trust. The Commission cannot fulfill this responsibility by allowing its lands to be used for other public needs unless fair compensation is provided.

2/ The Ninth Circuit Court of Appeals later reversed the District Court in Keaukaha-Panaewa on jurisdictional grounds rather than on the merits of the conclusions of law described. 588 F.2d 1216 (1978). The U.S. Supreme Court refused to review the decision. 62 L.Ed. 2d 33 (1979). (Denial of a writ of certiorari does not signify the Supreme Court's views about the legal merits of a case.)

3/ See Background Paper on Land Transfers.

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B. THE OBLIGATION TO MAKE THE TRUST PROPERTY PRODUCTIVE

In Ahuna, the Hawaii Supreme Court determined that a second fundamental trust obligation is to use reasonable skill and care to make the trust property productive or simply to act as an ordinary and prudent person would in dealing with his own property.

If possible, Hawaiian Home lands should be made available for homesteading by the beneficiary. The homesteader in Ahuna was deprived of half of a farm lot because a county roadway extension was to be built through the area. The Hawaii Supreme Court concluded that it would be unreasonable for a prudent landowner to leave almost four acres of agricultural land in an unproductive state because of a mere possibility that the land might be used for a highway in the future.

The Hawaiian Homes Commission should take care to ensure that Hawaiian Home lands provide the maximum benefits possible for the beneficiaries and the program. Where reasonably possible, the beneficiaries should be allowed to use Hawaiian Home lands for homesteading purposes.

C. THE OBLIGATION TO HOLD AND PROTECT THE TRUST PROPERTY FOR THE BENEFICIARIES

It now seems well established that other state and county agencies may not control the use of Hawaiian Home lands except under very limited circumstances. The Hawaii Supreme Court has noted that the Department of Hawaiian Home Lands received exclusive control of Hawaiian Home lands. Section 206 of the HHCA specifically provides that the "powers and duties of the governor and the Board of Land and Natural Resources in respect to lands of the state shall not extend to lands having the status of Hawaiian Home lands. Ahuna at p. 338.

A state attorney general's opinion reached a similar conclusion:

> A review of the pertinent provisions of the HHCA indicates that the congressional intent was to create a class of lands separate and distinct from other public lands to be utilized for the rehabilitation of the Hawaiians and to vest control over the use of such lands

> in the Hawaiian Homes Commission and not in any other government agency. [Opinion No. 72-21 of the Attorney General of the State of Hawaii (October 2, 1972).]

Thus, the Hawaiian Homes Commission has an obligation to protect Hawaiian Home lands from encroachment or use by public and private non-beneficiaries.

In Keaukaha-Panaewa Community Association v. Hawaiian Homes Commission, a U.S. District Court judge ruled that the Hawaiian Homes Commission Act has the obligation to hold and protect the trust property for the beneficiaries under the HHCA. In that case, the Hawaiian Homes Commission had allowed the County of Hawaii to convert 24 acres of Hawaiian Homes farm lands into a flood control channel pending a land exchange to be worked out. When this action was challenged, the Commission issued a license to the County for a dollar a year.

The Court rejected this attempt to legitimize the taking and determined that the Commission may not lawfully permit Hawaiian Home lands to be used for the benefit of persons who are not beneficiaries under the Hawaiian Homes Commission Act without first obtaining reasonable compensation for such use based on sound economic and accounting principles.

While many of the questionable transfers which deprive the beneficiaries of the use of trust lands no longer occur, the Department of Hawaiian Home Lands continues to permit the use of much of its land by public authorities without compensation. Until such improper uses are resolved, the trustee will continue to fall short of meeting its fiduciary obligations.

D. THE OBLIGATION TO ADHERE TO THE TERMS OF THE TRUST

It is now generally accepted that the Hawaiian Homes Commission Act is the trust instrument which the trustees or Hawaiian Homes Commissioners must follow faithfully. At times in the past, they have failed to do so.

In the early 1970's, the Department established a use permit system whereby homesteaders were initially awarded agricultural plots on a permissive use basis rather than receiving 99 year leases. This action was challenged in Ahuna v. Department of Hawaiian Home Lands, and a State Circuit Court Judge declared the use permit system unlawful. The

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Court noted that the Department was acting in good faith and that the permissive use system might have its merits, but determined that Section 207 of the HHCA only authorized the Department to issue 99 year leases. Ahuna at p. 330.

The Hawaiian Homes Commission must follow the terms of the trust as embodied in the Hawaiian Homes Commission Act even if it believes that a different course might prove more beneficial. If the Commission wishes to deviate from the terms of the Hawaiian Homes Commission Act, then the Act must be amended.

E. DUTY TO RENDER A SATISFACTORY ACCOUNTING

Another responsibility of a trustee is the duty to render a satisfactory accounting. Steiner v. Hawaiian Trust, 47 Haw. 548 (1964); Manchester Bank of Pono Indians v. United States, 363 F.Supp. 1238 (N.D. Cal. 1973). It is well accepted that a trustee has a duty to keep accurate records and to allow the beneficiary to inspect accounts to determine that the trust is being properly administered.

In order to comply with this trust obligation, the Department of Hawaiian Home Lands must upgrade its financial accounting so that its books remain in an auditable condition.4/ Similarly, the Department should work towards eliminating discrepancies in its land inventory record keeping system.5/

III. UNRESOLVED QUESTIONS AS TO STATE TRUST RESPONSIBILITIES

While the trust responsibilities of the Hawaiian Homes Commission now seem well defined, no court has specified the nature of the obligation owed the Hawaiian Homes program by the state and its people under Article XII of the State Constitution. Some beneficiaries contend that the Hawaii Constitution obligates the state to provide adequate funds to allow the rehabilitation of all eligible beneficiaries by placing them on the land.

4/ A recent review found the financial records of the Department unauditable. Review of Hawaiian Homes Commission Program, Audit Report of the Inspector General, U.S. Department of the Interior (September 1982), pp. 44-51.

5/ See Background Papers on the Land Inventory and Record Keeping System.

Others have criticized the practice of leasing Hawaiian Home lands to non-beneficiaries to generate revenues in order to meet the administrative costs of operating the program.6/ Such critics feel that the leasing program causes a conflict of interest for the Department, which is forced to choose between making land available for use by the beneficiaries for homesteading and leasing lands to non-beneficiaries to generate funds to meet its administrative expenses, including salares.7/

In the 1978 Constitutional Convention of the State of Hawaii amended Article XI, Section 1, (Renumbered Article XII) to delete language which provided that "the legislature may from time to time make additional sums available..." [to the Department]. In place of the language deleted, the Constitutional Convention inserted the following provision:

> The legislature shall make sufficient sums available for the following purposes: (1) development of home, agriculture, farm and ranch lots; (2) home, agriculture, aquaculture, farm and ranch loans; (3) rehabilitation projects to include, but not limited to, educational, economic, political, social and cultural processes by which the general welfare and conditions of native Hawaiians are thereby improved; (4) the administration and operating budget of the department of Hawaiian home lands; in furtherance of (1), (2), (3), and (4) herein, by appropriating the same in the manner provided by law.

The Constitutional Amendment appears to have had little effect on funding for the Hawaiian Homes Program. The legislature has continued to provide some funds through the allotment of General Obligation Bonds.

6/ Levy, Native Hawaiian Land Rights, 63 California Law Review 848, 878 (1975).

7/ Section 213(f) of the Hawaiian Homes Commission Act requires the entire receipts derived from leasing available lands to be deposited in the Hawaiian Homes Administration Account.

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Some may argue that the use of the term "sufficient funds" left the determination of what funds would be sufficient to the state legislature.8/ Others may contend that the Constitutional Convention was without power to usurp the spending powers of the state legislature especially in light of the ceiling on state spending imposed by the same Constitutional Convention. (Article VII, Section 5)

The Constitutional Amendment to Article XII, Section 1, does direct that the administration and operating budget of the Department of Hawaiian Home Lands would be met through state appropriations. The Committee on Hawaiian Affairs of the 1978 Constitutional Convention provided the following comments on this provision:

> It is clear to your Committee that the intent and spirit of the Act would be better served by releasing the department of its present burden to generate revenues through the general leasing of its lands. Your Committee decided that through legislative funding this dilemma would be resolved. In that manner more lands could be made available to the intended beneficiaries.9/

Despite the constitutional amendment, the state legislature has not appropriated funds for the administration and operation of the Department of Hawaiian Home Lands. The Department has continued to lease lands to non-beneficiaries to generate revenues to administer the program and meet its operational expenses.

8/ The State has allocated over 40 million dollars in General Obligation Bonds to the Hawaiian Homes program for site improvements and home loan fund capitalization since 1975. Some have estimated that at present costs, the Department of Hawaiian Home Lands would need the staggering amount of nearly 500 million dollars to satisfy the present residential waiting lists. See Department of Hawaiian Home Lands Program Accomplishments (1975-1981).

9/ Standing Committee Report No. 56 of the Committee on Hawaiian Affairs, Convention Documents, Hawaii Constitutional Convention of 1978, p. 632.

This procedure of leasing lands to generate revenue has been challenged in Kaniho v. Padeken, Civ. 6108, Third Circuit. In this action, beneficiaries claim that the Hawaiian Homes Commission has violated its fiduciary responsibilities by leasing Hawaiian Home lands at Panaewa on the Island of Hawaii to non-beneficiaries for a 38 acre shopping center complex. One claim is that such leases are no longer lawful and are not required because the legislature is mandated to appropriate sufficient revenues to fund the administration of the program under Article XII of the State Constitution. A decision in this case may shed more light on the new funding provisions of Article XII.

Given present constraints on state spending, it appears unlikely that the State will assume the administrative expenses of the Department of Hawaiian Home Lands unless required to do so. Consequently, revenues from Hawaiian Home lands will continue to be required to administer the Department, unless legal challenges to this practice force some alternate arrangement. The Land Status Committee has formulated its recommendations under the assumption that present funding patterns will remain the same.

IV. CONCLUSION

Since its admission to the Union, the State of Hawaii has occupied the position of trustee with respect to Hawaiian Home lands and the native Hawaiian beneficiaries of those lands.

The State, particularly within the last decade, has made substantial and successful efforts to improve the State's performance as a trustee. These efforts have resulted in the greatest number of beneficiaries receiving benefits in the history of the program.

Nevertheless, substantial problems remain and the trustee will not meet all of its fiduciary obligations until more has been accomplished. As detailed in the findings of the Task Force and in the Background Papers, the State has not, for example, identified with precision the "available lands" that constitute the corpus of the trust; it has not maintained auditable financial records and statements; and it has entered into conveyances of Hawaiian Home lands that have not been authorized by law.

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The Department of Hawaiian Home Lands should continue its efforts to correct shortcomings in the administration of the Hawaiian Homes Commission Act.

Although the Department of Hawaiian Home Lands is the central agency of the State charged with administration of the HHCA, it cannot by its own acts alone eliminate the shortcoming of the State in its role as trustee.

The responsibility of the State under Article XII of the Hawaii Constitution to provide sufficient funds for the Hawaiian Homes Program should be clarified.

The Governor of the State should require all other pertinent State agencies to cooperate fully with the Department of Hawaiian Home Lands to remedy ongoing breaches of trust.

APPENDIX 9

BACKGROUND PAPER

A RIGHT OF ACTION FOR
BENEFICIARIES OF THE HHCA

I. INTRODUCTION

It is now well established that the Hawaiian Homes Commission, which oversees the Department of Hawaiian Home Lands, owes special duties and responsibilities to eligible native Hawaiians in administering the Hawaiian Homes Program. The Hawaii Supreme Court has ruled that in dealing with eligible beneficiaries collectively or individually, the Hawaiian Homes Commission must adhere to the high fiduciary or trust duties normally owed by a trustee to its beneficiaries.1/ The Court indicated that it will strictly scrutinize the actions of the government in this regard.

While the trust responsibilities of the Hawaiian Homes Commission seem well established, it is less clear who is entitled to hold the Commission accountable for a breach of trust.2/

II. A PRIVATE RIGHT OF ACTION UNDER FEDERAL LAW

The Hawaii Admission Act provides that public lands, including Hawaiian Home lands, shall be held as a public trust for, among other things, the betterment of the conditions of native Hawaiians, and that the use of these lands or proceeds and income from these lands for any other object shall constitute a breach of trust for which suit may be brought by the United States [Hawaii Admission Act at 5(f)].

In Keaukaha-Panaewa Community Association v. Hawaiian Homes Commission, 588 F.2d 1216 (9th Cir. 1978), the United States Court of Appeals ruled that native Hawaiians had no right to bring a lawsuit in federal court against the

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1/ Ahuna v. Department of Hawaiian Home Lands, 64 Haw. 327, 338 (1982).

2/ For a discussion of the trust responsibilities of the Hawaiian Homes Commission, see Background Paper on State Trust Responsibilities.

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Hawaiian Homes Commission for breach of trust.3/ The Court ruled that the Hawaii Admission Act granted only the United States the right to bring suit for breach of trust and refused to interpret the Act to authorize private parties to sue. The Court also concluded that the Hawaiian Homes Commission Act (hereafter "HHCA") did not provide the basis for a federal lawsuit because the HHCA was no longer a federal law.

As a result, only the United States may act to enforce the trust provisions of Section 5(f) of the Hawaii Admission Act in federal court. At present, if the beneficiaries wish to enforce the Admission Act trust, they must persuade the United States to act for them.

III. THE HAWAII CONSTITUTION AND THE HAWAIIAN HOMES COMMISSION ACT

Upon statehood, the State of Hawaii entered into a compact with the United States to assume management and disposition of Hawaiian Home lands. The new state agreed to adopt the Hawaiian Homes Commission Act as a provision of the State Constitution.

Article XII, Section 2, of the State Constitition provides as follows:

> Section 2. The State and its people do hereby accept, as a compact with the United States, or as conditions or trust provisions imposed by the United States, relating to the management and disposition of the Hawaiian home lands, the requirement that section 1 hereof be included in this constititon, in whole or in part, it being intended that the Act or acts of Congress pertaining thereto shall be definitive of the extent and nature of such compact, conditions or trust provisions, as the case may be. The State and its people do further agree and declare that the spirit of the Hawaiian Homes Commission Act looking to the continuance of the Hawaiian homes projects for the further rehabilitation of the Hawaiian race shall be faithfully carried out.

3/ The U.S. Supreme Court refused to review the decision of the Ninth Circuit. 62 L.Ed. 2d 33 (1979). (Denial of a writ of certiorari does not signify the Supreme Court's views about the legal merits of a case.)

While these provisions clearly impose trust responsibilities on the state and the Hawaiian Homes Commission, the question remains whether the State Constitution or the HHCA allow beneficiaries to sue to enforce the trust in state court.

In Ahuna v. Department of Hawaiian Home Lands, at p. 333, the Department of Hawaiian Home Lands suggested to the Hawaii Supreme Court that the beneficiaries had no right to sue to enforce the trust obligations imposed by the Hawaiian Homes Commission Act. The court noted, but did not resolve this issue, because the question was not properly raised at the trial court level.

If faced with the issue in the future, it seems likely that the Hawaii Supreme Court would find that the beneficiaries have a right to sue for breach of trust in state court. In deciding whether to imply a right to sue, where such a right has not been expressly granted, the Hawaii Supreme Court has weighed factors similar to those used by the Ninth Circuit in the Keaukaha case.4/ However,

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4/ In the case of Reliable Collection Agency v. Cole, 59 Haw. 503, 506 (1978), the Hawaii Supreme Court employed the first three of the four factors specified in Cort v. Ash, 422 U.S. 66 (1975), to deny a claim to an implied right of action for a debtor to sue under a statute regulating collection agencies. The Ninth Circuit employed all four of the Cort factors to deny native Hawaiians the right to sue under the Admission Act in Keaukaha-Panaewa, supra. The four factors described by Cort v. Ash are:

> First, is the plaintiff "one of the class for whose especial benefit the statute was enacted,...--that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? Third, is it consistent with the underlying purpose of the legislative scheme to imply such a remedy for the plaintiff?... And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?

in the state arena, the same factors which caused the court in Keaukaha to deny a private right in federal court weigh in favor of implying a private right of action in state court. Nevertheless, no court has ruled on tnis question.

IV. THE NEED FOR A RIGHT OF ACTION BY THE BENEFICIARIES

While the right of beneficiaries to bring suit against the Commission for breach of trust has not been established, the need for such a right is clear.

The United States is vested with authority to sue for breach of trust under the Admission Act, but federal agencies cannot be expected to oversee the decisions of the Hawaiian Homes Commission on a day-to-day basis. Until recently, the United States has made no attempt to monitor the Hawaiian Homes Program nor have agencies of the United States provided a meaningful, independent review of Hawaiian Home land transfers, as may have been contemplated by the Admission Act.5/

Nor can the State of Hawaii be relied upon to effectively supervise the trust. There is an inherent conflict between the needs of native Hawaiian beneficiaries for land and revenue and similar needs by other state agencies for the general public. Because of this conflict, and the independent status of the Hawaiian Homes Commission, the state executive branch should not assume sole responsibility for assuring that the Hawaiian Homes Commission satisfy its trust responsibilities.

By the very nature of their position, beneficiaries and associations of beneficiaries have proven to be the parties most actively concerned with proper administration of the trust by the Hawaiian Homes Commission. They are directly affected by Commission decisions. Beneficiaries and homestead associations have demonstrated a keen interest in the administration of the program over the years. Despite the lack of an express right to use, they have resorted to court action to enforce various provisions of the trust and

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5/ See Background Paper on Conveyance Methods

the Hawaiian Homes Commission Act with significant results.6/ The United States has recognized the need for this role by the beneficiaries and has consistently supported the right of the beneficiaries to bring actions for breach of trust in either state or federal court.7/

6/ See for example:

Keaukaha-Panaewa Community Association v. Hawaiian Homes Commission, No. 75-0260 (Haw. D.C. 1976), which determined that land exchange and licensing procedures of the Department were contrary to provisions of the HHCA and in breach of trust.

Aki v. Beamer, Civ. 76-0144 (D.C. Haw. 1978), found that the appropriation of Hawaiian Home lands by a governor's executive order was a violation of the HHCA.

Price v. Dept. of Justice, C.A. No. 80-2794 (D.D.C., filed Oct. 31, 1980), which provided the impetus for the formation of the State Federal Task Force.

Ahuna v. Department of Hawaiian Home Lands, 64 Haw. 327 (1982), which determined that the policy of awarding agricultural lots on a permissive use basis violated provisions of the HHCA. The appeal described the nature of the trust obligations of the Department of Hawaiian Home Lands in detail for the first time.

Kaniho v. Padeken, Civ. No. 6108, Haw. Third Cir., has challenged the practice of leasing Hawaiian Home lands to non-beneficiaries for revenue production.

7/ See Brief of the United States, submitted as Amicus Curiae in Keaukaha-Panaewa Community Association v. Hawaiian Homes Commission, supra, dated May 1978, appended as Attachment A; and a letter from U.S. Department of Justice, Land and Natural Resources Division to the United States Commission on Civil Rights dated August 13, 1979, appended as Attachment B.

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V. RECOMMENDATION

Present legislation concerning the Hawaiian Homes program does not expressly grant or deny beneficiaries the right to sue to enforce provisions of the Hawaiian Homes Commission Act or to hold the trustee accountable for its fiduciary responsibilities. As a result, the right of beneficiaries to sue to enforce the trust remains a source of dispute between the administration of the Department of Hawaiian Home Lands and the beneficiaries.

Nothing precludes the state legislature from expressly granting the beneficiaries the right to sue in state court to enforce the provisions of the trust. Such legislation could take the form of an amendment to the Hawaiian Homes Commission Act or could be enacted as state legislation separate and apart from the Act. Inasmuch as such a measure would appear to expand and extend the rights of the beneficiary, congressional approval for such an amendment to the Hawaiian Homes Commission Act would not be necessary.

Similarly, Congress has the power to reverse the result of the decision in Keaukaha by enacting federal legislation which would grant native Hawaiians access to federal courts to enforce provisions of the Hawaii Admission Act. Such legislation should not amend the Admission Act, but should be enacted as a separate federal law.8/

Legislation should be enacted by both the State Legislature and Congress which will allow beneficiaries to sue to enforce the trust in either state or federal court.

8/ The Background Paper on Federal Responsibilities describes the Hawaii Admission Act as a compact which could be modified only with great difficulty.

ATTACHMENT A

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

No. 77-1044

KEAUKAHA-PANAEWA COMMUNITY ASSOCIATION, ET AL.,

Plaintiffs-Appellees

v.

HAWAIIAN HOMES COMMISSION, ET AL.,

Defendants-Appellants

ON APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE DISTRICT OF HAWAII

BRIEF OF THE UNITED STATES, AMICUS CURIAE

OPINION BELOW

The unreported "Finding of Fact; Declarations and Conclusions of Law; Order" by District Judge Dick Yin Wong appears at pages 551-555 of the reproduced record.

JURISDICTION

The final order of the district court was entered September 1, 1976 (R. 561). This Court's jurisdiction rests on 28 U.S.C. 1291.

QUESTIONS PRESENTED

1. Whether an association which represents Native Hawaiian beneficiaries under the Hawaiian Homes Commission

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Act and individual native Hawaiians have standing or a right to bring an action to enforce provisions of that Act or the Hawaii Admission Act in United States District Court under 28 U.S.C. 1331. 1/

2. Whether the United States alone is authorized to bring an action to enforce compliance with provisions of the Hawaiian Homes Commission Act or the Hawaii Admission Act.

STATEMENT

This brief is submitted by the United States in response to the order of this Court, dated April 21, 1978, requesting the Department of Justice to file "a brief as amicus curiae on the jurisdictional aspects of the case."

The district court below has concluded that the Hawaiian Homes Commission Act (HHCA) is "a Federal law, a State law and also the substance of a compact between the United States and the State of Hawaii" (footnote omitted; R. 203). This was also the ruling of the District Court of the District of Hawaii (Pence, J.) in Kila v. Hawaiian Homes Commission, Civ. No. 74-12 (Sept. 17, 1974, unreported, R. 70).

The HHCA of 1920 was first enacted as a law of the United States on July 9, 1921, 42 Stat. 108. This act was

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1/ We have assumed that the Court in its order of April 21, 1978, inadvertently asked for our views on the standing or right of "appellants" to bring this action and intended for our brief to address the appellees' standing or right.

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codified to the United States Code under Title 48 Section 691 to 716. The United States, in providing for the admission of the State of Hawaii into the Union, P.L. 86-3, 73 Stat. 4, March 18, 1959, provided in Section 4 of the Admission Act that Hawaii, as a condition to obtaining statehood, enter into a compact with the United States relating to the management and disposition of the Hawaiian home lands. This Act provides that "* * * the Hawaiian Homes Commission Act, 1920, as amended, shall be adopted as a provision of the Constitution of said State * * *," 73 Stat. 5. In Section 5, subsections (a)-(e) of the same Act, the United States, with certain exceptions not here relevant, granted to the State of Hawaii title to all public lands and other public property held by the United States immediately prior to the State of Hawaii's admission into the Union. Section 5(f) of the Act 73 Stat. 6, provided that "such lands and the income therefrom, shall be held by said State as a public trust for the support of the public schools and other public educational institutions, for the betterment of the conditions of native Hawaiians * * *, for the development of farm and home ownership on as widespread a basis as possible for the making of public improvements, and for the provision of lands for public use." Section 5(f) continued: "Such lands, proceeds, and income shall be managed and disposed of for one or more of the foregoing purposes in

such manner as the constitution and laws of said State may provide, and their use for any other object shall constitute a breach of trust for which suit may be brought by the United States."

The State of Hawaii, in its Constitution, Article XI, Section 1, adopted "as a law of the state," the Hawaiian Homes Commission Act of 1920. Section 2 of Article XI of the Constitution is the compact with the United States which was validated by the ratification by the people of the State of Hawaii in adopting their constitution. Subsequently, Title 48 U.S.C. 691-716 dealing with Hawaiian Homes Lands was omitted from the United States Code, but the HHCA has never been formally repealed.

VIEWS OF THE UNITED STATES

1. The Hawaiian Homes Commission Act is a law of the State of Hawaii and is no longer a federal law. - The United States does not believe the HHCA, which Congress required the State of Hawaii to adopt as part of the law of that State upon admission, is presently a federal law.

The United States, upon the admission of Hawaii as a state, turned over to the new state the public lands, with certain exceptions not relevant here, to which it formerly held title. These lands were to be administered by the State under the HHCA which had been adopted by its constitution

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as a "law of the State." The intent of the United States that these lands be held and administered by the State of Hawaii under the HHCA is, we believe, clear. The principal restriction retained by the United States, set forth in Section 4 of the Admission Act, provides that the essential purposes of the HHCA may not be changed without the consent of the United States. 73 Stat. 5. Significantly, Section 7(b)(3) of the Statehood Act provided that "all provisions of the [Statehood] Act of Congress approved [on the approval date] reserving rights or powers to the United States, as well as those prescribing the terms or conditions of the grants of lands or other property therein made to the State of Hawaii are consented to fully by said State and its people." 73 Stat. 7.

Certainly the HHCA became a law of the state of Hawaii upon the completion of the compact which the State was required to enter into with the United States as an condition to obtaining statehood. If this Act were still a federal law, there would have been no need to have obtained the consent of the State and its people to the reservation of certain residual rights relating to the manner that parts of the HHCA may be amended or repealed as set forth in Section 1 of Article XI of the Hawaiian Constitution.

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To our knowledge, the Federal Government has taken no action in this area of State concern since this Act became a State law and we know of no intent to retain the HHCA as a federal statute and no federal purpose to be served in having the HHCA regarded as a federal law. 2/

2. The fact that the HHCA was required to be "adopted as a law of the state," as a compact with the United States, does not operate to make the HHCA a federal law. - Section 4 of the Hawaii Statehood Act, Pub. L. 86-3, 73 Stat. 4, provides in pertinent part:

> As a compact with the United States relating to the management and disposition of the Hawaiian home lands, the Hawaiian Homes Commission Act, 1920, as amended, shall be adopted as a provision of the Constitution of said state * * *.

The State did enter into the required compact with the United States. See Article XI of the Hawaii State Constitution, Titles 1-4 of 1 Haw. Rev. Stats., and Proc. 3309, August 21, 1959, 24 F.R. 6868, 73 Stat. c74, admitting the State of Hawaii into the Union.

The fact that the HHCA was required to be enacted into state law by the Hawaiian Admission Act, and was adopted by the State, does not operate to make this act a federal law any more than would Section 3 of the Hawaiian Admission Act, which required that the State Constitution always be republican in form, make the State Constitution a federal law. Had Congress intended the HHCA to remain a

2/ Stated differently, the provisions of the Admission Act and the adoption of the State Constitution ended federal administration of the HHCA. The pertinent provisions of the HHCA have since been administered by the State and Congress has not evinced any intent to the contrary.

federal law it certainly could have so provided. What it did, however, was to have the HHCA Act adopted as a State law, permitting the State to manage and dispose of the lands granted by the United States to the State by Section 5, subsections (a)-(e) of the Admission Act "* * * in such manner as the constitution and laws of said State may provide * * *."[3/]

The state entered into the compact with the United States as required by the Admission Act. The compact was completed; and nothing remains to be done. The compact is not in issue and the present action does not raise any questions concerning it.

3. Hawaiian Natives can properly bring suit in federal court to enforce the trust provisions of Section 5(f) of the Hawaii Admission Act. - In response to the second issue posed by this Court, we believe that there is presented here a federal question. Native Hawaiians can properly bring suit in the United States District Court under 28 U.S.C. 1331(a) to enforce the provisions of the Hawaii Admission Act, 73 Stat. 4, which is a law of the United States.

The Hawaii Admission Act, Section 5(f), provides that the lands, proceeds, and income granted to the State under that Act shall

> be managed and disposed of for one or more of the foregoing purposes in such manner as the constitution and laws of said state may provide,

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3/ Under the circumstances, this congressional direction is at least an expression of implied intent that the HHCA itself was no longer to be considered a federal law.

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> and their use for any other object shall constitute a breach of trust for which suit may be brought by the United States. [Emphasis added.]

Since the State of Hawaii holds the lands conveyed to it by the United States for the benefit of the Native Hawaiians, they, as beneficiaries of that trust, would seem to be entitled to bring suit in the United States District Court to compel the State to fulfill the terms of the trust. Obviously, beneficiaries under a trust have standing to maintain an action to protect the trust or to compel administration of the trust intended by its creation and purpose. See Poafpybitty v. Skelly Oil Co., 390 U.S. 365 (1968), which we believe is analogous. 4/

The Admission Act, in our opinion, is clearly a federal law. It specifies the purposes of the transfer of property and the restricted uses of the lands and income for the benefit of Native Hawaiians. Under these circumstances, our view is that Native Hawaiians may maintain a suit in federal court to enforce the purposes of the trust as expressed in the Admission Act and that there is "federal question" jurisdiction.

4. The United States could have properly maintained a suit in federal district court for a breach of any of the trust duties specified in Section 5(f) of the Hawaii Admission

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4/ Cf. Capitan Grande Band of Mis. Indians v. Helix Irr. Dist., 514 F.2d 465, 470-471 (C.A. 9, 1975), cert. den., 423 U.S. 874; State of New Mexico v. Aamodt, 537 F.2d 1102, 1107 (C.A. 10, 1976), cert. den., 429 U.S. 1121.

Act, 73 Stat. 4. - Section 5(f) of the Admission Act, quoted above, clearly authorizes the United States to file suit to enforce the State's responsibilities with respect to the Hawaiian trust lands.

The Hawaii Admission Act, 73 Stat. 4, is unquestionably a federal law. A suit to enforce a provision of that Act would be a suit arising under a law of the United States within the meaning of 28 U.S.C. 1331, and, if commenced by the United States, jurisdiction would be in the federal district court. 28 U.S.C. 1345.

CONCLUSION

We believe that the district court incorrectly found the HHCA to be a federal law. However, we believe that the district court did have jurisdiction over this matter under 28 U.S.C. 1331(a) to enforce Section 5(f) of the Hawaii Admission Act. That law specifies that the lands conveyed by the United States to the State are to be managed and disposed of for certain stated purposes. Clearly, the United States could have filed suit to enforce this trust as the statute explicitly states. In addition,

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the Hawaiian beneficiaries could also properly bring an action to enforce this trust.

Respectfully submitted,

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MAY 1978

90-1-0-1208

ATTACHMENT B

United States Department of Justice
ASSISTANT ATTORNEY GENERAL
LAND AND NATURAL RESOURCES
DIVISION
Washington, D.C. 20530

August 13, 1979

Mr. Philip Montez
Regional Office Director
Western Regional Office
United States Commission
on Civil Rights
312 North Spring Street
Los Angeles, California 90012

Dear Mr. Montez:

This is in response to your letter of August 1, 1979, concerning the Hawaii Admission Act of March 18, 1959, 73 Stat. 4, as amended, and the Hawaiian Homes Commission Act of 1920, as amended, 42 Stat. 108. The identical letter has been sent to the Secretary of the Interior.

As your letter points out, section 5(f) of the Admission Act requires that certain lands, including the Hawaiian home lands, conveyed by the United States to the State ". . . be held as a public trust for the support of the public schools and other public educational institutions, for the betterment of the conditions of the native Hawaiians . . . for the development of farm and home ownership on as widespread a basis as possible for the making of public improvements, and for the provision of lands for public use." As noted by the Ninth Circuit, section 5(f) contains an ambiguity since it arguably provides that the Hawaiian home lands may be used for the same general public purposes as other federal lands conveyed to Hawaii pursuant to the Admission Act. Keaukaha - Panaewa Community Association v. Hawaiian Homes Commission, 588 F.2d 1216, 1218, n. 2 (9th Circuit, 1979). A petition for certiorari is now pending in the Supreme Court. The subsection further provides that: "such lands, proceeds, and income shall be managed and disposed of for one or more of the foregoing purposes in such manner as the constitution and laws of the said State may provide, and their use for any other object shall constitute a breach of trust for which suit may be brought by the United States."

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In response to the specific questions raised in your letter, we offer the following:

1a. The Department of Justice would have the exclusive litigation authority if suit were brought by the United States to enforce the trust. The Department of the Interior has no authority to file lawsuits on behalf of the United States. It is our view, however, that individual beneficiaries of the trust may also file suit if they believe the trust to have been violated. In this respect, we disagree with the Ninth Circuit's decision in Keaukaha - Panaewa, supra.

1b. The authority to initiate litigation is discretionary, rather than mandatory.

1c. If a request is made to the Department of Justice by the Secretary of the Interior to initiate legal action against the State of Hawaii, we would review the request to determine if the case has legal merit and factual support. If we find that a meritorious case exists, we would file an action.

1d. No actions have been filed by the United States.

1e. The State of Hawaii has the responsibility to administer the lands in accordance with the Admission Act and the State's constitution and laws. If the State fails to fulfill this responsibility, the United States is authorized to bring suit to require the State to fulfill its responsibility.

2. The series of questions in Part 2 relate to the function of the Secretary of the Interior. We defer to the Department of the Interior with respect to these issues.

Sincerely,

James W. Moorman

James W. Hoorman
Assistant Attorney General
Land and Natural Resources Division

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